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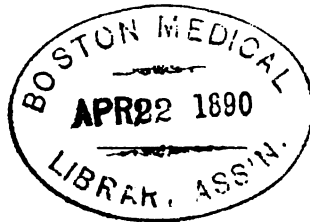
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VOL. XI.

SHORTENING THE ROUND LIGAMENTS, FOR DISPLACEMENTS OF THE UTERUS, (ALEXAN- DER'S OPERATION).

BY H. I. OSTROM, M.D., NEW YORK.

Mechanical derangements are best overcome and cured by mechanical means. Dynamics are powerless to set a broken bone, or reduce a dislocated joint; they are equally unable to replace and maintain in position a displaced uterus. The analogy, however, between the broken bone and dislocated joint, and the displaced uterus, is not a perfect one, for the latter condition is rarely found uncomplicated with some preceding systemic or organic disorder, that predisposes to, if it does not cause, the local derangements; a history that only in rare instances belongs to the former class of accidents.

This all but constant factor, constitution, will necessarily modify the purely mechanical treatment of a displaced uterus, but I believe it to be nevertheless true that while we are directing our tissue-reaching remedies against this,

and with them seeking to remove tissue relaxation and pelvic congestion, we are working at a painful disadvantage, and the parts we seek to cure are unable to benefit by our remedies, so long as we depend wholly upon them, and do not accept assistance from mechanical replacement and support. This seems so clearly within reason, that one is almost disposed to apologize for more than referring to it as an established therapeutic fact; but there is reason to believe that general practitioners are sometimes reluctant to acknowledge the value of the aid they receive from mechanical appliances in treating uterine displacements, and are too willing to let cases run on, trusting to dynamic treatment alone for a cure. This is a reaction from the equally unscientific methods in vogue some years ago, by which all medical treatment was discarded as useless, and reliance placed wholly upon pessaries and kindred instruments. These are the two extremes which it seems necessary to touch before reaching the safe middle-ground, where a clearer judgment can be formed of the value of different methods of treatment. There are probably few educated physicians who to-day treat their cases of uterine displacement with instruments alone. Such practice has rightly become a relic of the past; but we should be careful not to fall into the opposite error, and discard, because of former abuse, means of cure that are of such great value in the cure of displacements of the uterus.

In the more rational treatment of uterine displacement, mechanics holds an important place, and we have to meet the question in individual cases, not whether we shall employ mechanical means to replace and so hold the uterus, but rather the special mechanical principle and its method of application, that we will call to aid us in accomplishing this object.

Mechanical means for treating displaced uteri fall within two divisions: those that support and hold the organ in position, acting from the vagina, that is, from below; and

those that hold the uterus up by drawing upon the natural sustainers of the organ,—the round ligaments,—or by fastening the fundus to the abdominal walls, that is, acting from above. In the first division belong pessaries, in their endless variety of shape; to the second, Dr. Alexander's operation of shortening the round ligaments, and Dr. Kelly's operation of hysterorrhaphy.

It is foreign to my present purpose to discuss pessaries and their use; they are unquestionably of service, and as unquestionably represent one of the most powerful principles in mechanics, the lever; their failure to effect a cure may generally be traced either to our inability to apply the lever properly, the fulcrum being more or less movable, or the fact that merely holding the uterus up and in place does not of necessity either strengthen or shorten the tissues that physiologically maintain the organ in the axis of the pelvis. All that the vagina and pelvic floor can do to hold the uterus in position is imitated by the pessaries, but those anatomical parts are secondary in maintaining the normal relation of the organs within the female pelvis; for while they form a wall of support, that wall is not a sufficient barrier if the round ligaments are relaxed, and permit the uterus to slip down, and its fundus to turn toward the sacrum. With the fundus in its normal position, the pelvic floor supports the reproductive organs, but when the fundus is directed backwards, either in retroversion or retroflexion, the vagina and perineum, or any mechanical apparatus acting from these structures, can not be relied upon to hold the uterus in position, especially if a cure is the object of treatment.

The key to the normal position of the uterus is a degree of ante flexion, and this is chiefly maintained by the round ligaments. The broad ligaments, and the utero-sacral ligaments, together with intra-abdominal pressure, assist in preserving "physiological ante flexion," but the burden of this position rests upon the round ligaments.

Whatever treatment we may adopt, the use of pessaries, restoration of the perineum, or reduction of the calibre of the vagina, our success in curing uterine displacements, in a great measure, will depend upon our ability to restore the round ligaments to their proper degree of tension. The assistance rendered by the broad ligaments in maintaining the forward inclination of the uterus is probably considerable, and the frequency with which they are the seat of inflammation, and inflammatory exudation, may with reason be regarded as a cause, as well as an effect, of uterine displacements. But the round ligaments are the anatomical suspenders of the uterus; all other structures contributing to its physiological position are accessories, not principals.

Dr. Alexander's operation of shortening the round ligaments for uterine displacements, is an endeavor to restore the anatomical plan of the female pelvis; to bring back to their functional activity parts that have become useless and no longer able to perform their office in relation to the uterus. It is what may be called a physiological operation, and as such, better adapted to accomplish uterine health than any other method that has been yet proposed.

We are, however, in a proportion of cases obliged to record failure to obtain the benefit sought, or in fact any improvement; and we may with propriety inquire the causes of disappointment.

These are, principally,—excluding those cases in which no round ligament can be found,—lack of care in the selection of the cases to be operated upon; insufficient attention to the preparatory treatment, and failure to appreciate the importance of continued treatment after the operation, before the patient is dismissed as cured.

While shortening the round ligaments is an anatomically correct operation for the cure of displacements of the uterus, it is not to be concluded that every variety or every degree of displacement is amenable to this method of treatment. Its sphere of usefulness, as has been insisted upon by Dr.

Alexander, lies chiefly, if not exclusively, in backward displacements of the fundus. Where prolapsus is dependent upon retroversion or retroflexion, other things being equal, shortening the round ligaments may reasonably be expected to yield brilliant results. But if the case is one of prolapsus, the result of sub-involution, pelvic congestion, falling of the pelvic floor, or giving away of any of the means of uterine support, though in any one of those conditions the round ligaments will be abnormally stretched, to shorten them, without at the same time seeking to overcome the causes of the displacement, must result in more than failure, for the round ligaments are not strong enough, nor can they be made sufficiently secure to bear the entire weight of the uterus. Again, in cases of long lasting uterine displacement of any variety, the utility of the operation is open to question, for in such cases the round ligaments are usually atrophied from over-distension—I found an illustration of this very point in a case recently operated upon, in which I could find no trace of either round ligament—and, even if found, are inadequate to hold the uterus within the axis of the pelvis.

For the selection of cases for operation, the following may be of assistance. Those uterine displacements that can not be corrected by an enforced anteflexion, and those cases in which, from the previous history, we are led to believe the round ligaments have become permanently over-distended, are probably not favorable for Alexander's operation. On the other hand, if our examination shows the uterus to be easily replaced, and the entire displacement corrected by anteflexion; and if the pelvic tissues present a degree of firmness leading to the belief that the round ligaments are still capable of being excited to the performance of their function, Alexander's operation may with reasonable assurance be expected to cure the uterine displacement. It is unfortunately true, that few cases when brought to the surgeon for treatment present this favorable

grouping of conditions. Are we, therefore, to refuse to operate upon all cases that are not thus favorably conditioned for this method of treatment? I think not, for I am confident from my own experience, and that of other operators, that much may be accomplished by before and after treatment, to render even the most unfavorable cases not altogether beyond relief.

It is assumed that any constitutional fault that may exist will receive careful attention; that such local conditions as pelvic congestion, sub-involution, endometritis, etc., will receive either general or local treatment, or both, according to the requirements of the case and the predilection of the surgeon; that constipation, the almost constant companion of uterine diseases, will be removed, and the intestinal canal, if need be, forced to a free daily evacuation. These matters it is taken for granted will form a part of the preparatory treatment of almost any operation upon the female pelvic organs. But what I desire to emphasize as an essential part of the treatment preparatory to shortening the round ligaments, is the judicious and persistent use of uterine supporters. By this it will be understood I mean mechanical appliances acting from the vagina. My own preference is for the vaginal tampon, medicated, or saturated with glycerine, as the case may require; or, better still, to pack the vagina, the uterus having been replaced, with small pieces of wool covered with absorbent cotton. But there are undoubtedly cases that are successfully treated with a well-adjusted pessary. The packing system has the disadvantage that it requires more frequent attendance than is always convenient or desirable, but for accuracy of work, and definite results, I think there is no question between the merits of the two methods.

Now from this mechanical part of the preparatory treatment, we may expect to accomplish restoration of the uterine and pelvic circulation, and thus overcome one of

the opposing factors in the treatment of uterine displacements, and also to afford an opportunity for the round ligaments to regain their muscular tone, for by lifting the uterus we relieve the tension that has been placed on those structures. By judicious attention to this part of the preparatory treatment, many cases, otherwise beyond assistance from the surgeon, can be rendered hopeful ones for an operation.

In the after-treatment, mechanical appliances will also fill an important part. Some method of uterine support, preferably that supplied by the vaginal tampon, should always be employed. If the case has not been a severe one, one or two months of treatment may be sufficient, but if the displacement is of long standing, requiring an extended period of preparatory treatment, a correspondingly longer period of after-treatment will be requisite.

Judicious exercise in the open air,—walking is generally to be preferred to riding—abstinence from all sexual relations, until the uterus no longer requires support, are conditions that should be insisted upon.

Touching the question of pregnancy, from the few cases that have been reported as occurring after shortening of the round ligaments, the operation seems in no way to interfere with the normal progress of gestation. Upon physiological grounds, there is reason to expect that the rising of the uterus out of the pelvis, which accompanies development of the ovum, and the anatomical changes that take place in the uterus and its appendages as gestation proceeds, would effect a favorable influence upon the round ligaments, and tend to strengthen their suspending power.

42 WEST FORTY-EIGHTH STREET.

UTERINE SARCOMA (?) CURETTE : HYDRASTIS.

BY EDWIN M. HALE, M.D., CHICAGO.

CASE.—A large, fine-looking woman, a native of New Orleans, aged 50. Her menses had been regular up to within a year; since then, skipping. In November, 1887, she was attacked one night with violent hemorrhage.

Dr. D. T. Nelson, professor of gynecology in Rush Medical College, was called in. He arrested the flooding by means of ergot and the tampon, but it occurred every few days, until she became very anæmic. A uterine examination was made, and he found the organ greatly enlarged, and on using the curette he got substances which seemed to indicate malignant disease. The scraping was subjected to an examination by Dr. Cary, pathologist and microscopist to St. Luke's Hospital, who pronounced it "probably sarcoma."

Relying on this opinion, Dr. Nelson informed the patient that an operation was required, and he wrote to the woman's son-in-law, a prominent surgeon in Virginia, that he thought it would be necessary to extirpate the uterus.

The patient very naturally dreaded so important an operation, and on consulting her son-in-law he advised calling in some other gynæcologist, either in consultation or alone. I happened to be the physician decided on. An examination showed a greatly enlarged and flabby uterus. Its depth was four and one-half inches. The introduction of the sound caused considerable hemorrhage. A quantity of broken-down tissue was removed by the curette, and was examined by Dr. A. B. Hale (my son) and Dr. Frank Johnson, who alternated with Dr. Cary as pathologist and microscopist to St. Luke's. Both failed to find evidences of sarcoma in the substance examined. They selected their specimens from nearly a teaspoonful of material.

I decided on a thorough curetting of the uterus, first using Thomas' wire curette followed by Simon's sharp-edged instrument, and removing about a tablespoonful of a substance, fibrous, with a brain-like appearance mixed with it. The uterine cavity was then swabbed out with compound tincture of iodine; a tampon of hamamelis applied, and absolute rest enjoined.

No more hemorrhage occurred for nearly a month, and then it appeared so much like a profuse menstrual flow that I allowed it to go on for five days. At that time it seemed inclined to grow worse, when the uterus was again curetted as before. The diseased tissue occupied the posterior wall of the fundus. It had a distinct, ridgy, cockscomb-like feeling, but its removal was not attended with the slightest pain. In fact no amount of manipulation caused any pain at any time! This time I applied a 30 per cent. solution of chromic acid to the interior of the womb, and prescribed tincture hydrastis, 20 drops three times a day, to cause contraction of the uterine blood-vessels, as in cases of sub-involution.

After this operation six months elapsed before there was any flow of blood from the uterus, and then it was slight—but as it continued for six days I decided on an examination. The cavity of the womb then measured only three inches. The curette was used, and a slight ridge was found low down on the posterior wall. This was scraped down smooth. Nearly a year has elapsed. The woman is now the picture of ruddy health and strength. The uterus is so small as to indicate senile atrophy.

The diagnosis of this case is in doubt. Gusserow ("Encyc. of Gynæcology") says a microscopic examination is very unreliable. It may have been a case of diffuse sarcoma, "sarcoma of the uterine mucous membrane" (Virchow). "The proliferating tissues are always very soft, grayish white, medullary, vascular, and protrude, usually in forms resembling a cockscomb, above the healthy mucous

membrane. Their surface is ordinarily undergoing disintegration. It is quite uneven and covered with blackish or brownish shreds. These new formations may be easily distinguished from benign hypertrophies of the uterine mucous membrane, *i.e.*, granulation tissues, both by their anatomical and clinical features. In most cases the uterus is enlarged, the os is patulous, and the finger easily enters the uterine cavity. In the great majority of cases the sarcomatous degeneration originates in the sub-mucous connective tissue of the body of the uterus."

This case may have been one of endometritis fungosa, but in this disease the cervix is usually closed. In sarcoma the uterus is large, infiltrated, and usually painful when moved. These points are absent in endometritis fungosa. In sarcoma the submucous tissues are infiltrated. If this case had been sarcoma, would a complete recovery like this have occurred? In sarcoma, besides the anæmia there is a decided cachexia. In this case there was only anæmia. I have removed (curetting) many cases of fungoid degeneration of the uterine mucosa. But the removed substances did not look like this.

Anyhow, the treatment appears successful, which is the main point, and the terrible operation of extirpation of the uterus has been avoided.

The reduction in size of the greatly enlarged womb may have been chiefly due to the curetting, but I believe hydrastis had something to do with it. I forgot to say that she used the hot prolonged douche for two months. This probably had its influence.

We should not be too hasty to advise a serious surgical operation on the uterus; we should first use milder surgical measures. On the other hand, we should not err by resorting to too mild measures. I am certain that the administration of medicines, no matter how carefully selected from their symptomology, would have been of no value in this case. Others may honestly differ with me in

this matter, but I judge from the results of considerable experience in such cases, for I once tried to treat them by the old method, and always failed.

HYDATIDS OF THE UTERUS.

BY J. H. SHERMAN, M.D., BOSTON.

Read before the Mass. Surgical and Gynæcological Society.

Mrs. B., 29 years of age, seven years married, had had two children and one miscarriage. Last child two years old. Was regular after weaning last child until the last of February of the present year, when the menses ceased. April 25, had an unusual flow, which lasted for a week, after which an almost continuous show, until I was called, May 28. Patient said she had had a physician in attendance since she began to flow, and he had called in counsel. The decision was that she was threatened with a miscarriage, and the indications were to wait for further developments.

I found patient weak, emaciated, extremely nervous and apprehensive, suffering from almost continuous nausea and frequent vomiting, with much pain and tenderness in abdominal region. On palpating found uterus enlarged to what might be expected at the fourth month of gestation. The enlargement did not seem hard or elastic, but doughy. The os uteri was slightly opened and patulous. I agreed with my predecessors in diagnosis, and thought I would wait for developments. Gave the patient supportive treatment and waited four days. Seeing that she was losing strength, and the nervous symptoms increasing, resolved to explore the uterus.

I summoned my colleague, Dr. Asa Smith, to administer ether, and commenced dilating the os. I soon got one finger, then two, into the uterus, and felt what I supposed to

be a degenerated placenta. As much of the mass was secured as possible and withdrawn, which upon examination proved to be, not a placenta or a part thereof, but hydatid cysts. The cysts were joined together by a sort of connective tissue, and varied in size from a small pea to a Malaga grape, and were filled with a transparent gelatinous fluid. I scooped out a good-sized pewter wash-basin full of this jelly-like substance, two quarts or more, curetted the uterus, and syringed it out with carbolized water.

The womb contracted readily to its normal size; all vomiting, nausea, and nervous phenomena disappeared, and the patient is now fast regaining her strength. These cases I think must be rare, as it is the first one] that had occurred in my practice of thirty years and several physicians with whom I am acquainted, of extensive practice, have never met with a case.

This is a very good report so far, and had I read it as I intended at our June meeting the following sequel would not have appeared, but candor seems to demand its statement. The hydatids were removed from the uterus June 1, and patient gradually improved until June 18, when I ceased attendance, and soon after she discharged her nurse and attended to her usual household duties. I was summoned again July 9; found patient suffering from an attack of pleuritis. She sat by an open window sewing, and took cold. She also had pain and tenderness in the uterine region, and a dark, bloody, somewhat offensive discharge from the vagina. Intra-uterine injections of carbolized water were used, aconite and bryonia were given to meet the chest complications. The patient continuing to grow worse, on July 13 called Dr. Boothby in consultation. The doctor gave an unfavorable prognosis of the case, but suggested no material change in the treatment. A gradual failure of vital force ensued, and she died from exhaustion July 20. There is reason here for conjecture as to the ultimate cause of death in this case. Was

there some portion of the hydatid formation that was not removed from the uterus as the cause of disturbance, or was there uterine inflammation coincident with inflammation of the pleura and due to the same cause, viz., sitting in a draft of air? That the uterus was freed from all morbid products would appear from the fact that she had an interval of three weeks from the time I ceased attendance until I was called again, when there was no unusual vaginal discharge.

NOMA PUDENDI.

BY W. H. LOUGEE, M.D., LAWRENCE, MASS.

(Read before the Boston Gyn. Club.)

When I entered the house to see this patient, I encountered one of the most terrible odors I had ever met, and upon inquiry learned the following history: The patient, a little girl of two years, while on a visit to an adjoining city took whooping cough, and after three weeks of that took German measles. The measles ran a natural course, giving the physician (old school) no trouble. Feb. 25, when the measles had about gone, the nurse discovered some black spots upon each labia, and these spots seemed inclined to spread very rapidly. The physician's attention was promptly called to these spots, when he, becoming alarmed, called other physicians, until six had been summoned. All did what they could until noon of the third day, when they informed the mother of the child that the little patient could not live twenty-four hours longer, and if she wanted to take her home alive she must do so that afternoon. They informed her that they could pack the child in disinfectants, so that she could take her on the cars, assuring the mother that the journey would not shorten her life one hour. The mother's anxiety to reach home with her child alive was so great that she decided to make

the attempt. Child was packed, and the mother reached her home, two miles from my office, with the child alive, but in a very deplorable condition. I was summoned, and saw her for the first time on the evening of March 28, three days after the attack. When I entered the house the stench from this disease was terrible to endure, and decomposition had reached that stage that when I took hold of her legs and raised her hips from the bed, large sloughs from both labia fell off.

The parts were discharging a dark and very offensive secretion. I prescribed arsenicum 2x and apis mel. 1x every hour in alternation. Also ordered the diseased parts enveloped in a poultice composed of two parts slippery elm and one part charcoal, wet up in a 2 per cent. solution of carbolic acid, and applied very hot and moist.

Saw patient next morning, and found her no worse and no better. She fretted and cried all night, and would not take the least nourishment. Dissolved one-quarter grain of sulph. morphia and 150th of a grain of sulphate of atropin in four teaspoonfuls of water, and gave one spoonful every three hours till quieted. Knowing that this would create thirst as well as quiet her pain and restlessness, I ordered the nurse to make a glass of egg, milk and brandy, and when she called for drink of any kind to let her take that. By creating this thirst we succeeded in getting her to take during the first twenty-four hours four goblets full of the egg, milk and brandy.

For medicine she got after the first night secale cor. and arsen. in alternation every half-hour. Ordered poultice wet up in secale water, so that each poultice should contain about one drachm of fluid extract of secale.

March 30. Patient rested better during the night, and upon examination of the parts I found a line of demarcation forming around the whole diseased parts of both labia. Encouraged by this, I continued same treatment internal and external. At this visit I noticed face and eyes puffed,

and a fine rash all over her body, bowels swollen badly, and urine very scanty, very high colored, and very stinking. Her general color was bronzy. Ordered an enema to relieve the bowels, and continued treatment same as the day before.

March 31. Patient has had several passages from the bowels, had a good night, and a complete slough, including the inside of the entire pudendi, had come off. All odor had disappeared. The cavity made by the sloughing was frightful to look at on so small a child. It seemed as though her whole insides would surely come next. Every part from which the slough had been thrown off presented healthy granulations. At this visit the mother informed me that the stool came out through the vagina, which of course alarmed me not a little; but upon a careful examination per rectum I found the recto-vaginal septum intact, as not the slightest perforation could be found. The hymen also was perfect.

April 1. Little patient passed a good night; swelling external much better, as also the swelling about head, face, and in the bowels. Following this slough I had the parts covered with a fine powder composed of equal parts of iodoform and boracic acid. Discontinued poultices, and used an ointment made by Buffington, composed of cosmo-line, ham., iodol, and tannic acid. Continued medicine at longer intervals.

April 2. Patient much better. Continued same treatment.

April 4. Noticed white patches forming on clitoris similar to diphtheritic patches on the throat. Applied to these patches a 40 per cent. solution of nitrate of silver, and then packed the parts in absorbent cotton, saturated with one drachm of borax dissolved in one ounce of glycerine.

April 6. Doing nicely. Continued treatment.

April 8. Patient was in such splendid condition that the case was discharged cured.

CAUSE OF INFANTILE CRYING.

BY J. A. GANN, M.D., WOOSTER, OHIO.

Read before the Ohio State Medical Society (Homœopathic).

To the student of symptomatology desiring a field of study uncomplicated by imaginings and the defective deductions of symptom-harassed patients, a study of the various conditions of infancy affords an exceptionally rich field.

It is the purpose of this paper, however, to consider those conditions of infancy free from the usual conditions of sickness, or those dependent upon inflammatory or morbid pathological conditions, but which are productive of a more or less constant state of worrying or crying, by which certain babies are known as crying babies in contradistinction from those which, as their mothers say, "are just as good as they can be." There are some who claim that a child never cries without a cause—that crying is always an evidence of suffering; while others, whether better informed or less charitable, claim that many a baby cries from the manifestation of some innate predisposition to be worrisome. If such babies exist, we believe them to be in the small minority. With nearly all children born in the most approved conditions, one of the first and welcomed evidences of a perfectly normal condition—especially of the respiratory system—is a series of more or less hearty cries. Even this, though welcomed by all, is an evidence of discomfort of the little one. The sudden change of temperature from that of the interior of the body to that of the outer air—as a rule always cooler than the space the little one vacated—produces a shock to the system which voices itself in as hearty a protest as possible to the change. This is, however, soon remedied by proper attention from the nurse; and the quiet sweetness of the babe soon becomes

a source of comfort; and the first cries of the baby are forgotten in the quiet rest that usually follows.

As before stated, it is not the purpose of this paper to refer to the many diseases which in children may be attended with crying, because attended with suffering; but only to those conditions which may properly be referred to as under the control—very largely—of proper hygienic measures.

Now, while the border-line between these two classes may at times be unsteady, it will generally be due to the fact that the cause of the crying has not been properly recognized; and having been permitted to continue, more weighty pathological conditions have followed.

Basing our thoughts on the hypothesis that babies do not cry unless from a cause, we will divide these causes into: First, External causes, and, second, Internal causes. Under the first class we might cite: First—Crying from soreness, induced by some severe labor, when being handled. Second—Too tight bandaging. Third—The prick of a pin. Fourth—The chafing of clothing. Fifth—Intertrigo. Sixth—Insufficient clothing. Seventh—Heat.

Second class of causes: Internal: First—Hunger. Second—Thirst. Third—Indigestion with its train of colics. Fourth—Hernia. Fifth—Dysuria. Sixth—Constipation. Seventh—Prolapsus recti. Eighth—Teething. Ninth—Sleepy, but does not want to sleep. Tenth—Passion on the part of the mother. Eleventh—Nervousness of child—as fear. Twelfth—Nursing too rapidly. Thirteenth—Too frequent nursing. Fourteenth—Earache. Fifteenth—Sore throat, or mouth. Sixteenth—Child nursing when the mother is pregnant. Seventeenth—Broken bones, or dislocations.

J. G. Holland in his "Bitter-Sweet," referred to some of these conditions, when he wrote of babies as follows:

" Warped by colics, and wet by tears,
Punctured by pins, and tortured by fears."

We will consider the causes in the order named, and briefly suggest the means of alleviation :

First. Crying from soreness of the body when being handled. This frequently arises after tedious labor ; which fact may be the sufficient cause for the child's crying, and would naturally suggest itself—and also the hygienic remedy: Let it alone as much as possible.

Second. Too tight bandaging. This is a frequent cause of crying, and can be remedied by the nurse intelligently considering the demands of the digestive and respiratory functions of the baby, and loosening the bandage.

Third. The prick of a pin. This is a frequent cause of crying, yet not so frequent as before safety-pins were so generally used. The crying is characterized by its suddenness and violence ; and is fully as liable to occur in the normally cheerful baby as in the one more inclined to be worrisome. This will suggest the examination for and removal of the offending instrument.

Fourth. The chafing of clothing. This is readily discovered at the undressing of the child, when the rough or stiffened clothing may be caught, as it were, in the act of producing the irritation, and the reddened cuticle calls for relief. If the child is old enough it may seek to change its position in the cradle or nurse's arms to obtain relief. A too vigorous first bath may predispose to this difficulty.

Fifth. Intertrigo. This is especially a difficulty with fat babies. All degrees of intertrigo made be found, from a simple redness to a deep redness, and even exudation of serum, or bloody serum upon the surfaces. Here the strictest attention to hygienic measures is necessary. The baby's food should be carefully inspected, for in the great majority of cases it is due to unsuitable food or deranged digestive function, causing a more or less acid reaction to all the secretions of the body, and a poisoned, irritated skin is the result. Powders, etc., if used externally, should be used discreetly, as their indiscriminate use aggravates

the existing difficulty. Lycopodium powder is one of the best and simplest, while the internal use of the same remedy—if necessary—or cham., rheum., mer. cor., is helpful.

Sixth. Insufficient clothing. This is occasionally a cause of crying with children, sometimes depending upon the pride, sometimes on the poverty, of the parents: and the little one, to be made as presentable as possible, is left blue and shivering and shuddering. The diagnosis of the difficulty is fairly easy and suggests the remedy.

Seventh. Too much heat. Here the reverse condition exists. Amid blankets, flannels, and fancy coverings, and in a room already as warm as the mother may wish, the little one kicks, struggles, and cries, pleading as eloquently and forcibly as it can for release from its sweat-pack. A few vigorous rocks of the cradle, something new to attract its attention, may cause it to forget for the moment its discomfort, but only to be renewed when the diversion is past.

As inexcusable as this may seem, it is a frequent cause of crying, and its remedy is only to be found in a more reasonable appreciation of the child's requirements.

Secondly: The internal causes we will also consider in order. First. Hunger. This may be due to perfectly natural causes, and may be satisfied by the timely administration of the proper food. But cases frequently occur when the administration of the usual food is not sufficient to still the crying. This may be because the food is not adapted to the age and condition of the child, though the food itself may be nutritious; or the food may fail to possess nutritive properties in proper proportions. During the early hours, or days, of the infant's life, and before the mother's natural supply for the child may have made its appearance, the nurse, fearful that the little one will suffer from want of food, frequently inaugurates a colicky disposition by the dish of sweetened pap or water sweetened with the ordinary cane-sugar. Much of the difficulty could readily be

avoided if, instead of the above procedure, a little water sweetened with sugar of milk—which is nutritious—were given. And I have frequently seen colics removed and gentleness secured by this change of diet. The advancing age of the child will occasionally demonstrate the fact that the mother's milk is failing, has failed, or is unsuitable; and here comes the necessity of making selection from the various "best" preparations with which the market is flooded. The experiences of the physician may have demonstrated that any one of these standard foods may be good in some cases, but possibly not one in all cases. With some, cow's milk affords all that need be desired, and the little one thrives in the most approved manner. With others, this fails, and condensed milk affords a means that produces most gratifying results. For certain cases of "acid-conditioned" infants, where all milk preparations acted as gastro-intestinal irritants, the little one may thrive on Imperial Granum, especially where diarrhœa seemed to intensify the difficulty. For certain cases I have seen Mellin's Food fill the want; and this, too, I have seen yield to Carnrick's Food, and so on. It is perhaps impossible to predicate with certainty what food will be best adapted to the individual case, and yet a study of the analyses of these standard preparations and the peculiarities of each case may aid somewhat in the selection. Is the little one of the "acid make-up," with tendency to colic, sour vomiting, sour evacuations, etc., we should avoid those preparations rich in hydro-carbons, as these by their naturally inclined fermentative tendencies induce the difficulties we are trying to overcome. One of the most valuable adjuncts in these little cases of weak digestion I have found in a digestive preparation which I have been preparing and using for some time past, and which is made as follows: Pepsin 2 drs., pancreatina 2 drs., salycin 20 grs., lactic acid 40 grs., sac. lac. 6 oz.—tritrate together, and give in one or two grain doses after food.

Second. Thirst. Touissant very forcibly says on this subject that it is a mistake to suppose that because milk is a liquid food, it is at the same time a drink which is capable of satisfying the thirst of infants. Although milk appeases hunger, it makes thirst more intense after it has stood for a while in the stomach and digestion begins. It is thirst that causes healthy breast-nourished infants to cry for long periods of time in many instances. A few spoonfuls of water will soon relieve this evidence of distress.

Third. Indigestion, with its train of colics, is so intimately associated with the two previous divisions as to sustain the relation to them of sequel. But it is only to the acute, sudden attacks that we here refer. Here some known change in the diet may readily account for the suffering, and it is generally caused not so frequently by the feeding of unsuitable food as by the giving of food in quantity beyond the capabilities of the child to digest it. Manifestly, care should be exercised in the quantity administered; at the same time remember that in many cases of impaired digestion the occasional administration of a little water would assist in the performance of this function. In some children with whom the mother's milk generally agrees, a change in the mother's diet—especially to a fruit diet, or a diet too highly seasoned—may induce colic in the nursing child, the digestive powers of the child being so weak, especially up to the fifth or sixth month, as to render it especially liable to such influences. As before remarked, colics may be due to the excess of hydro-carbons in the food, and the deficiency of the nitrogenous and phosphatic elements. Some children, as soon as they are able to sit in a high chair, are placed at the table with other members of the family. Here the temptation to try the baby's growing digestive power is almost irresistible; and loving mother and doting father give the baby a taste of the "forbidden fruit." The habit grows, but the baby's stomach frequently sends its protests in the form of mental irritability, colics,

fevers, convulsions, and the whole train of deranged digestive symptoms. Meat-fed babies, like meat-fed animals of a lower type of life, are far more liable to crossness and irritability than are those whose diet is free from such stimulating food. The relish for an article of food is not always a safe criterion for its use, but it is frequently harmful in proportion to its relish. The management of such cases is suggested by referring to the causes that induce such conditions. Colicky babies should be kept warm, and during an attack hot application to the abdomen; the feet in warm water will frequently speedily relieve.

Fourth. Hernia. It is not so frequently a cause primarily as it is secondarily; as the crying is frequently productive of the condition, which, when produced, is a source of annoyance and suffering. The remedy (which may be difficult to apply) is: reduce the hernia and remove the causes that primarily induce the crying.

Fifth. Dysuria. This is by no means a novel cause, but it is often obscure in its etiology. Frequently nervous in origin, sometimes due to errors in diet, sometimes to rectal irritation, and catarrhal conditions of the urinary tract, considerable difficulty may be experienced in determining the exciting cause. There may be the presence of uric acid in the urine. It is a serious matter; and Vogel says that two-thirds of the children that die between the age of two and ten days die from this cause. Dysuria is characterized by writhing pains; by the child throwing itself back and stiffening out; there may be extreme sensitiveness in the region of the bladder; with this there is frequently retention of urine. The difficulty may often be remedied by proper hygienic measures, such as plenty of soft water as a drink, and warm poultices over kidneys and bladder.

Sixth. Constipation. This, regarded as a resultant of possibly several factors, and being a symptom, is to be met as such in its totality. The whole field of the child's dietetics and habits merits the closest scrutiny, and in no

department does physiological feeding meet a more certain reward. The discomforts and suffering of the child when attempting an evacuation are generally so aggravated as to attract the attention of the mother or nurse to the immediate cause of the suffering, and can only be overcome as the causes are removed.

Seventh. Prolapsus recti; and even actual fissures are found in certain aggravated cases. These are generally associated with constipation, but the more intense suffering during and continuing for some time after an evacuation, warrant a careful search for this difficulty, and distinguish it from ordinary constipation, though produced and removed in many cases similarly.

Eighth. Teething. This lets in a whole flood of tears and wails, and is the too frequent excuse for prescribing, and the still more careless diagnosis of the existing difficulties. While the pain incident to the teething process is many times very acute, and induces such perturbed conditions of the nervous and circulatory systems as to induce spasms and convulsions, yet these conditions are frequently aggravated by a general unsuitableness of the child's hygiene. Nature, though sometimes possibly at fault or at a loss to maintain the required balance of the nervous and circulatory forces incident to the development of the teeth, is generally on the alert, and by sympathetic flexions from the entire alimentary tract tries to prevent undue congestions with the consequent suffering during the teething process. There are generally a sufficient number of symptoms to call the attention of the nurse or mother to the teething process, when that is the cause of the crying, as the motions of the child will materially aid in the establishment of the diagnosis. The general hygienic surroundings of the little one demand investigation. Its hereditary predisposition may need some remedial assistance to put it on the right track, but the bathing, the food, the light, the air, the clothing—indeed the “life the child

leads," are more important than the hit or miss teething remedies so frequently prescribed on generalities.

Ninth. There is another condition which is almost as perplexing to the physician as it is trying to the mother, and that is when the child is sleepy, yet is unable to sleep. The mere prescribing of bell. will many times fail, if we are governed by this keynote alone, since the causes for this condition may be variously located. Now, perchance, to teething irritation, now to congestive irritation of the medulla—and this possibly reflex from gastric irritation, and when the almost fallen-asleep condition of the child receives a shock—apparently induced by fear of something—which causes a cry that impresses us that it is some form of suffering that induces this peculiar condition. The sleep of a child in pain is spasmodic, by fits and starts, and sometimes sleep is secured only as the result of exhaustion. Nearly every morbid condition may have this symptom attending it, and it is valuable as it enables us to discern with more clearness the extent to which the central nervous system is involved. As such it must be considered with other associated symptoms.

Tenth. Violent fits of passion upon the part of the nursing mother may induce conditions all the way from a mere nervous indisposition upon the part of the child to abdominal pains, convulsions, and even death. The coincidence of passion upon the part of the mother and suffering upon the part of the child might suggest the cause; the effects may be more or less lasting as the child was more or less susceptible.

Eleventh. Nervousness of the child, from fear, fright, or loneliness. It is manifested by expressions of relief when the condition which caused it is removed. Often placing the child in the mother's arms is all that is required to avert what otherwise might have resulted even seriously.

Twelfth. Nursing too rapidly is a frequent source of pain with children. Here the stomach, receiving its supply

faster than the digestive powers can dispose of it, sends up its protest, and the child drops the nipple to cry, but to take it again when the cause of the crying is less active. This may be frequently repeated during a single nursing. The remedy is: feed more slowly; take the nipple from the child's mouth, or if using the bottle use a nipple with such a fine perforation as to permit but a small quantity of the nourishment to pass through at one suction. In those cases where rubber-tubing is attached to the bottle—though this is not the best—an occasional pressure on the tubing will cut off the rapid supply, and thus accomplish the purpose.

Thirteenth. The too frequent nursing. Here we enter a field full of disputations and experiences. The physician may expect to run counter to many of the nurses and grandmothers, whose saffron and chamomile teas and dishes of pap are inevitably associated with the initiation of every baby into the mysteries of independent organic life. Every cry, from their standpoint, calls for the immediate administration of food, and unless the baby has extraordinary digestive powers it is exposed to the dangers that results from too frequent feeding. As a rule, a child may be nursed every two hours until two months old, then gradually lengthening the intervals, and when six months old not oftener than once in three hours. The intervals should be longer at night. For the abnormal hunger which sometimes torments children, the use of sac. lac in warm water, to which has been added a couple of drops of cream, will probably soothe the crying until the proper time for the administration of food arrives.

Fourteenth. Earache. Though properly the result of inflammatory action, it is so largely under the control of hygienic measures—frequently receiving no other—that it is here referred to. The twisting motions of the child, the pulling at the ears—unless they are extremely sensitive—the desire to hold the painful ear against something warm,

suggest the difficulty. The early recognition of the difficulty, and the application of heat may check the difficulty in the early stage; this should not be long continued, however, without medical aid.

Fifteenth. Sore throat or mouth. This is frequently due to imperfect hygienic conditions. Want of cleanliness, improper food, and improper eating are the most frequent causes. The difficulty in nursing or swallowing—or the child refusing to do either—will suggest an examination for the cause. Strict attention to hygiene will largely prevent any difficulty under this division.

Sixteenth. Nursing while the mother is pregnant is a frequent cause of the decline in health, cheerfulness, and even a cause of loss of life to the infant. The rule is, wean the baby if the mother is pregnant.

Seventeenth. Broken bones or dislocations. The very careless habit in many persons of lifting a child by an arm, and my experience with a child that was suffering with a dislocation caused in that way, suggest that I mention this inexcusable condition as a cause of great suffering and crying. The child's actions and loss of action, the position of the injured member, will suggest the cause of suffering and possible remedy.

Other causes may, perhaps, be found quite as productive in producing crying babies as those already mentioned; and possibly some would include numbers 12 and 13 with number 3 of this paper. The more readily overcome circumstances in the two numbers as being largely under *mechanical* control suggested the separate mention.

The causes thus far mentioned are probably the most frequent that present themselves in the ordinary routine practice of the physician, and his ability to diagnose them correctly, and to suggest the hygienic measures adapted to the existing conditions, is frequently as productive of as much credit to his professional skill, and eventually to his financial profit, as the successful carrying of a case through some more strikingly inflammatory condition.

THE INSANITY OF PREGNANCY.

BY H. H. CRIPPEN, M.D., O. ET A. CHIR., SAN DIEGO, CAL.

(Continued from Vol. 10, page 501.)

CHAPTER III.

ETIOLOGY.

Primarily we may look upon the mental aberration as dependent upon an overthrow of that unstable condition of mind which arises from causes associated with or following pregnancy, but there are many important secondary considerations to be referred to in this relation, since the disease presents, in so many cases, a double, a triple, or even multiple combination of causes. We may look upon the causes as predisposing and exciting, or again as moral, social, and physical; but rather than confuse by attempting any dividing line, it is preferable to consider each one separately.

Heredity.—The influence of heredity in predisposing to insanity is becoming well recognized. As in ancient Egypt the sameness of nature, its unchanging aspect, and the persistent recurrence of the same phenomena, strongly stimulated the natural disposition of men to follow the same occupation from generation to generation, the hereditary principle fixing the industrial pursuits,* so it is today in the inheritance of disease. In consequence of a sameness of conditions of long duration in the past, tissues may receive modifications that produce a proneness to suffer in a peculiar manner when exposed to ordinary exciting causes. In the instances which we are considering, the nervous system has been especially influenced in the particular direction to be pointed out under the discussion of pathology.

* An ancient Egyptian inscription bears witness to the fact that the profession of architect had been practiced in a given family for *twenty-three generations*.

Esquirol, in one hundred and forty-four cases, seen in private practice, found the hereditary tendency in one out of 2.8 cases. Hellyt, in Berlin, found it in fifty-one out of one hundred and thirty-one. Savage says that: "of two hundred and seven cases sixty-five acknowledged the taint, meaning thereby distinct insanity in the family." Of these he finds that twenty-two inherited it through the male and thirty-seven through the female side.

This is a slight confirmation of Baillarger's proposition that "the transmission of the mother's insanity is more to be feared with respect to the girls than the boys; that of the father, on the contrary, is more dangerous as regards the boys than the girls."

In my experience, twenty-three out of fifty-eight cases had a family history of insanity; in eight cases the mother had suffered from insanity, and in one case there was the remarkable history of daughter, mother, and grandmother, all having puerperal mania. In seven cases phthisis existed in the family, and in three there was a history of cancer. The question of the association of phthisis has arisen, but space forbids its discussion except as a complication.

We often are confronted with the embarrassing question of the policy of speaking against marriage in families that have so strongly marked neurotic tendency. It is a delicate question, but I firmly believe it is manifestly our duty to deprecate such marriages; it is truly a duty we owe to society at large, in view of the increasing ratio of nervous diseases. In cases of a double taint one ought to use the utmost endeavor to dissuade, and the same if there is a history of a degeneracy on one side and of insanity on the other.

Closely associated with heredity, as a predisposing cause, is the history of previous neuroses in the patient. In the histories of thirty-six cases out of fifty-eight, there existed previous nervous disorders varying from convulsion to derangements of the mind. These cases include fourteen

having previous attacks of insanity during pregnancy, during the puerperium or during lactation, of which eleven were second, and three third attacks. Montgomery mentions the case of a woman in which derangement of the mind recurred in eight pregnancies, and ceased only after delivery. It is well to know, then, that when a woman becomes insane at such periods there is reason to fear a recurrence should she again become pregnant.

Number of Pregnancies.—Most authorities affirm that primiparæ are most subject to the disease. Clouston found that twenty cases of puerperal insanity out of sixty occurred in relation to the first confinement. The remaining two-thirds happened, some in each confinement up to the eighth. Out of a list of fifty-three cases collected by Dr. Gundry, eighteen, or about one in every three, were found to be attacked with the disease in connection with their first pregnancy, or first parturition. In my own experience the proportion of primiparæ to multiparæ was twenty-six to thirty-two. The special point to be emphasized is that cases having children rapidly are liable to suffer from exhaustion.

Age.—The following table will show at a glance the proportion occurring at different ages :

Observer.	Number of Cases Reported.	From 15 to 20 Years of Age.	From 20 to 25 Years of Age.	From 25 to 30 Years of Age.	From 30 to 35 Years of Age.	From 35 to 40 Years of Age.	Over 40 Years Old.
Clouston ..	60	3	16	29	9	12	
Marcé.....	55	1	13	17	13	5	6
Savage ..	207		49	67	44	29	18
Crippen. ..	58	1	16	17	12	9	3
	380	5	94	111	78	55	27

From this table it would appear that those in the earlier periods suffer most from this condition, but, since at

this time fecundity is greater and the proportion of births greater, I believe that the tendency to insanity increases with age; for, with increasing age, we find woman less able to bear the trials, worry, and exhaustion of pregnancy, parturition, and lactation.

Qualitative Changes in the Blood.—A perverted condition of the blood quickly exercises a marked effect upon the function of the cerebral cells, and while I believe that quantitative changes in the blood-supply to the brain is most often the pathological condition, yet there certainly are cases of insanity of the variety under discussion that are due to a physical deterioration of the blood. Thus, in consequence of defective nutrition in the exhaustion produced by lactation, or by ill conditions of existence—as over-crowding, bad air, insufficiency of food, intemperance—we may find both predisposing and exciting causes.

Albuminuria I design to notice separately as a possible cause of nutritive changes in the blood. Sir J. Y. Simpson * lays great stress upon albuminuria as a cause of puerperal mania. In 1856 he first brought the connection of puerperal insanity with puerperal albuminuria before the Edinburgh Obstetrical Society, and subsequently, after observing a number of cases, formulated the following propositions:

“(a) That albuminuria precedes and attends the first access of puerperal insanity in a large proportion of cases; but perhaps not so frequently and so constantly as it precedes and attends upon attacks of puerperal convulsions. I have found it present in eight out of ten cases of puerperal insanity, at the commencement of the disease; and possibly it escaped observation in those two cases from not being looked for sufficiently early in their progress. For it seems to me,

(b.) “That the coagulability of the urine in puerperal in-

* “Diseases of Women,” 1872, p. 561.

sanity generally disappears within a short time after the attack commences, and hence disappears more speedily than happens in puerperal convulsions. The fire of disease goes on burning in these cases of insanity after the lighted match is merely applied, and the strange morbid clockwork runs on, as it were, after the key that wound it up is withdrawn.

I have seen all traces of albuminuria in puerperal insanity disappear from the urine within fifty hours from the access of the malady. The general rapidity of its disappearance is, perhaps, the principal, or, indeed, the only reason why this complication has escaped the notice of those physicians among us who devote themselves with such ardor and zeal to the treatment of insanity in our public asylums. As another proposition let me state :

(c.) "That when the puerperal insanity recurs in the form of successive attacks or explosions, each attack may be found connected with a new attack or advent of albuminuria." Though this extreme view of Sir J. Y. Simpson has not met with general acceptance, it must not be put aside, and I have intentionally dwelt upon it with the idea of emphasizing the fact that frequent analyses should be made of the urine of pregnant women.

There still remains for discussion a multitude of minor causes both predisposing and exciting. Miscarriage, that may or may not be followed by hemorrhage and exhaustion, is the cause of a considerable number of cases. Exhaustion may be dependent upon excessive vomiting in the early months of pregnancy, upon prolonged labor, upon severe hemorrhage at parturition, or may be dependent upon over-lactation. The use of chloroform has been blamed as an exciting cause, but I have no history of such a case. It is also possible that forceps may have a share in the causation, but as such, there are very few cases on record. Having considered the main points of predisposing and exciting causes as including many physical conditions, we may proceed to touch upon social and moral questions.

The French claim that mothers of illegitimate children are very liable to puerperal insanity. Though my experience has been entirely with cases of respectable married women, I can well understand that grief, shame, and chagrin may add to the causes of depression. Grief, too, from loss of husband or children during pregnancy, as well as a shock or fright, may lead to mental weakness.

Pregnancy especially, of all these periods, renders women more sensitive, nervous, erethistic, and excitable. At such a time an unkind word or look, indifference, or even thoughtless neglect on the part of the husband, weighs with a heavy burden upon an already unstable mind. In the case of melancholia the weight of sorrow presses energy and will out of place, and the whole intellectual life revolves around one painful fixed spot. Anxiety, with a dread of the pain and peril of labor, may produce a self-consciousness, passing into a morbid state. So varied are the causes, that one hardly knows where to draw the line, and to add to the difficulty it is rare to find causes acting singly; more often they are multiple.

SYMPTOMATIC INDICATIONS FOR REMEDIES FOR SUBINVOLUTION OF THE UTERUS.

BY B. F. BETTS, M.D., PHILADELPHIA.

Read before the Institute.

Very often the most prominent symptoms produced by uterine subinvolution are those referable to the mental sphere: the gastric and pelvic symptoms being next in importance, but so meager as to attract but little attention.

On the other hand, we know what a powerful influence mental emotions have in retarding the process of involution after parturition, just as functional action is disturbed

in the other organs, as the stomach for instance, when impaired digestion occurs in consequence of the mind having been impressed by either joyful or painful emotions. In the selections of a remedy for subinvolution we will therefore find the mental symptoms often the most important guides to enable us to choose between those drugs having pelvic symptoms so similar as to leave us without any other means of differentiation.

To secure perfect involution after abortion, parturition, or even menstruation, certain precautions have to be observed. When the parturient passage has been lacerated, it must be repaired, and when placental tufts remain, well-directed efforts should be made to remove them. After parturition disturbances of the circulation must be avoided in all cases, whether from chilling or emotional influences. After parturition the physician can never be sure of having secured to his patient the most favorable conditions for her future good health and comfort, until he has satisfied himself of the fact that the uterus is involuted. He should therefore examine each case before it is discharged from his care and supervision, about the fifth or sixth week after parturition, and if displacements exist, or pelvic inflammation and hyperplasia of the uterus have supervened upon some injury, treatment should be instituted until health is restored. For such treatment experience has demonstrated the fact that vaginal examinations should not be made earlier than the time mentioned above, unless urgently called for, and that pessaries should be dispensed with until all other methods by postural treatment and the application of cotton tampons have proved insufficient as supports for the dislocated organ. The condition of the patient's skin, bowels, and all the emunctories has to be considered, and whenever our efforts seem to be less productive of good than we had reason to hope for, the application of electricity will prove a valuable aid in bringing about a more rapid metamorphosis of tissue, as was ex-

plained in a paper I had the honor of reading before this bureau at our last meeting, since which time the method has gained many warm friends from amongst the foremost gynæcologists of this country and Europe, who have watched with interest the results obtained by Apostoli in his field of labor.

But we will not feel that we need to rely upon this as the only method of treatment. In a majority of cases our homœopathic remedies will yield such results, from careful applications, as to leave but little to be desired.

HOMŒOPATHIC THERAPEUTICS.

Actea racemosa.—The patient is nervous, restless, and greatly depressed in spirits, unable to sleep at night. Can not decide the simplest question without questioning her judgment. Fears she will lose her mind. Complaints of pains over the eyes extending along the base of the skull to occiput, or pain in the vertex from within outward, as if the top of the head would be lifted off.

Tenderness in the uterine region, and shooting pains in the region of the ovaries, either across the lower part of the abdomen or going up toward the chest. Infra-mammary pains of uterine origin.

Alumina is indicated in chlorotic women who have morbid appetites and such an inactive condition of the bowels as seldom requires them to attempt an evacuation. They go for days without stool. Sleep is restless, and they awaken with anxious palpitation of the heart. *Leucorrhœa* is copious and albuminous. It excoriates the vulva and is worse before and after the menses, which in turn leaves them exhausted in body and mind. The menstrual flow is scanty and quite painful at times, and the discharge is often pale and watery.

Ammonium muriaticum has been mentioned in connection with uterine hyperplasia.—A prominent indication is a tensive pain in one or the other groin, described as a

strained feeling which forces the patient to walk bent. Fat, bloated, indolent women are the best subjects.

Anatherum muriaticum.—Burning, cramping, gnawing pain in the uterine region, with debility and general prostration. Lancinating, distensive pain in the uterus. Burning pain in the uterus, extending to the region of the kidneys, with great weakness.

Argentum metallicum.—A pain in the region of the left ovary without much sensitiveness of the integument externally, with descent of the enlarged uterus, is quite characteristic of this drug. This pain is also felt in the back and extends to the front and downward.

Arg. nit.—We think of this remedy when there is weakness, almost paralysis of the lower limbs, associated with rigidity and pain in the muscles of the legs below the knees, and such gastric disturbances as are marked by frequent loud eructations, with despondency and weak memory in thin, "dried up" women, who are impulsive, excitable, nervous, irritable, and anxious.

Aurum is indicated when the characteristic mental symptoms are present, and in sanguine, light-haired, nervous women, tainted with mercury or syphilis. There is burning in the vaginal passage, and sensitiveness, sterility, menses delayed and scanty. Bruised, shooting, or drawing pains in the uterus. *Aurum muriaticum natronatum* is the preparation preferred by some, and from it good results have been obtained in the treatment of all forms of uterine hyperplasia.

Bella.—When acute symptoms predominate with back-ache as if broken, or pain through the pelvis, numbness in the legs, soreness or throbbing in the uterus. Pain diminished when sitting erect or standing, increased when bending over or walking. Spasmodic, clutching pain in the region of the uterus. Pelvic bearing down with profuse menses. Pains come on suddenly, and cease as suddenly as they come; pains run through pelvis.

Bromine will prove of service where there is vertigo, made worse from persons passing in a hurry, or increased by any passing object such as running water or moving vehicle. Accompanying this vertigo associated with the subinvolution there is an anxious state of mind developed, as if they were in the midst of impending danger, as if some one was going to step out from behind them. With the vertigo chill is often a feeling as if they would lose their sense all at once, and in one case cured, the patient fell to the floor upon two or three occasions and lost consciousness for a moment or two. After bromine 3x these symptoms disappeared, and the uterus became smaller. Women with light hair, blue eyes, and fair skin, and those with affections of the throat and chest, are good subjects.

Calcaria and its salts.—When the proper proportion between the adipose and muscular tissues of the body is not maintained, or when the osseous system is imperfectly developed, we may find the calcarias called for. The symptomatic indications for ostrearum are as follows: Apprehensive state of mind, fear of loss of reason, or that persons will observe her and suppose her to be crazy. Unable to sleep after 3 A.M. Vertigo on going upstairs. Cold, damp feet at night or pallid sweat on other portions of the body. Menses too frequent and profuse. Every little exertion or mental emotion causes a return of the flow. Whilst the fat and flabby scrofulous patient will require the ostrearum, the calc. phos. will be preferred in slender, narrow-chested, or phthisical patients, and the sulphurica in cases complicated by purulent infiltration of the parametric tissues, rather than by true abscess, caritus with pyogenic membranes lining them. When such pus-bags have existed for a long time, interfering with pelvic circulation and contaminating the whole system by their presence, the calc. sulph. will prove sufficient to remove the accumulation and reduce the hyperplasia of the uterine tissue.

Calc. iod. will be indicated in cases complicated with glandular enlargements.

Caulophyllum.—Weak, nervous, languid patients. Aching and dragging in the small of the back. After abortions rapid labors; uterus enlarged, and menses irregular and changed in character. Sanguine, rheumatic women, weak and nervous, hence the desire to remain quiet. Sensation of fullness in the head. Uterus congested with fullness and tightness in the hypogastric region, or severe spasmodic pains in the uterus followed by leucorrhœa or a menstrual flow.

The leucorrhœa is acid and seems to weaken the patient, and is attended with drawing pains in the lower extremities.

China offic.—Weak, delicate women who perspire easily and are very sensitive to drafts of air, or chilling influences. Menses too early and profuse, at which time they may complain of vertigo and ringing noises in the ears or faintness.

Convallaria majalis removes tenderness and soreness in the hypogastric region, as well as the aching which is an attendant in some cases of subinvolution of recent origin. The soreness is continuous and worse from motion; even breathing aggravates, as does coughing or laughing (bry.). Bearing-down pains at intervals like labor-pains in the abdomen, and in the lumbar region. Pains in the pelvic region are aggravated from motion, sitting up straight or leaning back; ameliorated by bending forward while sitting (bella. opposite).

Iodine preparations.—Leaving out of consideration the pathological indications, we may say that all the iodine preparations have the nervous irritability; of the halogen the combinations with arsenic and iron give us the most physical and muscular weakness.

The iodide of arsenic gives us the greatest prostration with the hard indurated glands and the other evidences of

the iodine scrofulosis. The burning pains and acid discharges from the pelvic organs will lead us to select this preparation. The impoverishment of the tissues arises from poor digestion, loss of appetite as well as imperfect assimilation. The blood is deorganized, the complexion sallow.

The iodide of iron give us more bearing-down pain, as if the uterus reached the vulva and was pressed up, when the patient seats herself. The albuminous discharge from the vagina, the bloated feeling after eating, and the mental and muscular weakness remind us of hydrastis, but the iron in combination gives us more of the disturbed circulation, flushing of the face, burning of the cheeks, etc. When these symptoms are met with in scrofulous women, suffering from subinvolution of the uterus, ferr. iod. 6x can be prescribed with confidence. The anæmia arises from such a disturbance in the hæmatogenic function as results in a diminution in the number of red blood cells in the blood; the complexion is pale, not sallow.

Iodide of potassium.—Kali iodatum is the remedy upon which reliance is placed by the allopathic fraternity. It is given to hasten tissue metamorphosis and the absorption of the products of inflammation. We may find it indicated in old, chronic cases having a syphilitic history, when there is a tendency to metrorrhagia, dysmenorrhœa, copious leucorrhœa, emaciation, and prostration. Before the menses there is frequent desire to urinate as from pressure of the uterus upon the bladder, which disappears when the flow becomes established.

Kali carbon.—What the iodide of potassium is capable of accomplishing in old, chronic cases of subinvolution, the carbonate will accomplish in recent cases if the conditions favoring its action are provided. She dates all her sufferings from a not very distant confinement. She is anæmic and fat, apprehensive, timid, and unable to sleep after 3 A.M. She is of lax fiber, as is indicated by the puffy appearance

about the eyelids. Atony of muscular tissue ; disposition to be affected by lifting, and over-exerting herself from slightest efforts. The pains are sticking and stitching in character, also darting ; increased from rest and lying on affected side (bry. opposite).

She suffers from pain in the back like a weight. Stitching pains about the sensitive uterus ; labor-like pains in the region of the uterus. Menses too early, too profuse, of an offensive odor ; blood acrid.

Stomach sensitive, distended, feels as if it would burst, or as if it were full of water. She may tell us that she always has her labor pains in her thighs—to the knees. The latter is a prominent indication for kali carb.

Lycop. will be indicated in some cases when subinvolution is attended with endometritis and much bloating of the abdomen and rumbling of flatus, especially in the left hypochondriac region or after repeated pregnancies, when the sexual function has been abused, and there is weakness of memory, confusion of mind, or absent-mindedness, with desire for solitude ; constipation, hepatic derangement ; a feeling of dryness in the vagina ; pain in the bladder and back before urination, with a deposit of red sediment on the bottom of the vessel after urine has been standing a short time ; also 4 P.M. aggravation.

Mel cum salc. was for years a popular remedy for diseases peculiar to women. Farrington, of Philadelphia, used it for fundal and cervical hyperplasia, when there was a feeling of soreness across the hypogastric region, from ilium to ilium. (Compare convallaria maj.)

Mag. mur. is a valuable remedy for nervous women suffering from pains down the arms, between the shoulders and down the back, with uterine complaints. Bearing down in the uterine region and spasmodic pains in the uterus. (Cauloph. actea race.) Menses very dark, with pains in back when walking, and thighs when sitting.

Natr. muriaticum when the menses are scanty and dark ;

the patient is melancholy, especially at the time of the menses, and impatient. She has a sallow complexion, and complains of dryness in the mouth, or dryness and rawness in the vagina. Constipation, headache in the morning; pain in the rectum during stool. Pelvic tenesmus, with pressure toward the vulva, relieved by sitting down, and disappearing upon lying upon the back.

Platina.—Menses dark, thick, profuse, and very exhausting in persons suffering from too strong sexual appetite, with painful sensitiveness and continual pressure in the external organs of generation. Haughty women who treat their friends and equals as beings inferior to them. For other cases platina may be of service where there is a melancholy, tearful disposition developed, with the intense sexual excitement.

Secale cor. Thin, scrawny women, who have had frequent miscarriages or borne children very fast; whose faces are sallow; skin shriveled, dry and harsh. Flow of blood from uterus passive, dark, and sometimes fetid.

Sepia.—Venous hyperæmia of the pelvic organs, with pelvic bearing-down pains; stitching pains from the uterus up through the abdomen. Vagina and vulva very sensitive. Bowels constipated; frequent desire for stool; frequent urging to urinate. Complains of headache on the left side of the head; left temple worse in the morning, and often associated with vertigo and nausea.

Staphasagria.—Sharp, shooting pains in the pelvis; painful sensitiveness of the sexual organs, especially when sitting; memory defective; indifferent, low-spirited woman who has abused the sexual function by masturbation or too frequent sexual indulgence. They are very sensitive to the least impressions, and feel hurt by the least word that seems wrong to them, or when involution can be traced to a mental influence arising from indignation with vexation at the lying-in period, which she has striven to suppress. She

feels very cross and irritable, even maliciously disposed, toward her friends.

Ustilago.—Discharge of blood from the uterus bright red, partly fluid, partly clotted. Passive congestion of the uterus, so that there is a slight oozing of blood after each examination. The tissues of the uterus feel soft and spongy; the os patulous.

A CASE OF LABOR.

BY H. R. MAXSON, M.D., NORTONVILLE, KAN.

I was called about 6 A.M., August 5, 1888, to attend Mrs. M. H. A. aged 19 years, in her third confinement, having attended her in her second on the 12th day of October, 1887, seven days less than ten calendar months previous. In this case she had been taken with pains at 4 P.M., August 4. On my arrival I found the pains quite severe and frequent. Upon examination I found the os well dilated and filled with a large sack of waters, the head just within reach above the pubic bone.

On rupture of the sack the head presented itself in the right occipital posterior position. The child was born with one pain—a male child, weight about three and one-half pounds. The size of the abdomen indicated the presence of twins. I made examination and found a second sack of waters, but could not detect any foetal parts with my finger. After a rest of some half an hour or so the pains came on again; the sack advanced (this was also quite large). After its rupture I attempted to discover what presentation there was, when, lo! I could not touch any presenting part, but could discover the placenta partially detached. As with the recurrence of each pain a considerable quantity of clots of blood came away, I introduced my hand. After carefully tracing the outline of the uterus, I found a contrac-

tion which held a part of the placenta and something else. I carefully detached the *quite small* placenta, when above a contraction about the size of a silver dollar I made out foetal parts. After trying to dilate the contraction with my fingers and apparently not succeeding, I sent for help, with the request to bring chloroform.

While waiting for assistance I gave a few doses of gels. 2x and cimicif. 3x. Soon the pains returned quite severely. Upon examination I found a breech presentation. With some difficulty I succeeded in delivering her of a male child quite discolored by the contractions upon it, weighing about three pounds. ~~With some difficulty I succeeded in getting it to breathe regularly and well before my help came.~~

The placenta appeared also to be held by the contraction, but my assistant ~~contracting with both hands over the uterus, and with some traction on the cord, it came away.~~

This was my first experience with hour-glass contraction, and the novelty to me was that two male foetuses in separate sacks, with separate placentæ, should also be separated by an hour-glass contraction. I gave no medicine or pressure over the uterus until I discovered the situation.

The mother was poorly nourished, being in poverty.

I left the mother and children apparently doing well, but in three hours word came to me that both children were dead. I saw the mother in twenty-four hours, when she appeared to be doing well.

SYMPTOMATIC INDICATIONS OF SOME OF THE NEOPLASMS OF THE UTERUS.

BY S. P. HEDGES, M.D., CHICAGO.

(Read before the Institute.)

A careful study of the various new growths to which the uterus is subject shows us that no other organ or tissue of

the body is more liable to these peculiar, morbid developments. Indeed, when one has exhausted the investigation of the various neoplasms of the uterus, he will find very few new forms elsewhere in the entire anatomical system. Hence the richness of the subject increases its interest. The several different tissues of the uterus have each a special tendency to peculiar growths. Each tissue, whether fibrous, muscular or mucous, gives its own characteristic to the morbid development from its stroma. And the modern nomenclature largely follows these histological facts in giving names to each new growth. The portion of the subject assigned me in the discussion is given at the head of this paper.

In treating this question I shall take as broad ground as possible, and hope I may not touch on territory belonging to another.

The uterus is a small organ, and the growths that may find a lodgment within it are various and dissimilar. But the symptoms by which they announce themselves are not by any means so varied and dissimilar. And herein lies one of the difficulties in a paper which has to be fenced in so exactly. The symptomatic indications of a tumor in the uterus are general rather than specific. By these symptoms we learn there is something there. But these symptoms must be assisted by other indications, both specific and constitutional, and by study and classifications of *all* the symptoms, before a true diagnosis can be made of the kind of growth or tumor. I have thought best not to include in this paper the microscopic indications, without which it is often impossible to make a diagnosis. I shall confine myself to the subjective and objective symptoms to be obtained from the patient, and by examination of the patient. This will include often a history of the patient, and much that is in the domain of etiology. The causes acting as predisposing to the neoplasms are of great importance in a proper and full symptomatology of any case.

Then, again, I shall treat this subject in the line of diagnosis, general and differential, rather than with a view to therapeutics. While the general subject before the bureau is uterine therapeutics, I am informed that others will cover the therapeutic indications.

Having thus defined the nature and field of this paper, and prepared the way to a clear understanding of it, I call your attention to the more particular work before us.

The neoplasms of the uterus are divided into two great classes, viz., benign and malignant. It is not always possible by subjective and objective symptoms alone to tell which we have to deal with. And this is true more especially early in the case, when it is so important to decide aright. Later in the case the signs of malignant growths make the differentiation clear enough. What we want to learn is how to distinguish them *early*, and this is the point of present interest in such studies.

The close attention which is now given to uterine and pelvic diseases is in the line of early diagnosis. And nowhere is this so vital to success as in malignant affections of the uterus. The recent view that cancer is primarily of local origin, and only constitutional as a secondary result, makes an early diagnosis the more necessary. Acting on this hypothesis, the sooner a cancerous growth is discovered the earlier it can be removed, before any of the adjacent glands or tissues are infiltrated by the destroying cells. I desire to emphasize the importance of this point,—early and correct diagnosis. While the uterus is so frequently attacked by new growths, by far the largest number belong to the class of fibroids in its widest limit. I wish to include in this class all the *hard*, firm tumors, whether springing from the connective tissues, as purely fibroids, or from the muscular tissue, as the myomata; and I also wish to include those tumors of mixed tissue, as the myo-fibroma and myxo-fibroma and myxoma, as well as those that retain their firm, smooth, rounded, and circumscribed form. Be-

sides these neoplasms, I shall include in the study of the common symptoms produced by intra-uterine growths the whole class of mucous and fibrous polypi, or mucous tissue growths as well as the glandular polypi which start from the glands as retention cysts. Here we have nearly all the benign neoplasms of the uterus, those especially of tumor form. When we have observed the symptoms common to these, yet more or less symptomatic, we will note the points of difference and where they are to be distinguished from each other. These conditions of growth, whatever the tissue involved, give rise to a common line of symptoms, and we can best study them together. Next let us consider the accident of *location*, for this is a controlling cause for a distinctive line of symptoms which will aid in forming our diagnosis. For instance, if one of these hard tumors is situated in the lower anterior segment of the womb or cervix, as it grows, we have symptoms of vesical irritation, frequent and painful micturition, or retention even, and when low enough to press on the urethra, symptoms of cystitis may occur. When these symptoms are obstinate, though there are no other pains and no other hemorrhage, we may think of a uterine fibroid.

Fibroids have properly been divided into sub-mucous, interstitial, and sub-peritoneal, according to location. This division is not arbitrary, but necessary, and our study of symptomatic indications will not be complete until we accurately classify our tumor into one of these divisions. Treatment can not be undertaken until we know just what and where the growth is.

Just here I wish to call attention to the very startling statistics as to the frequency with which these tumors are met with. It will be one of the valuable helps in weighing probabilities as to the kind of growth. According to Dr. Avernu's statistics fibroid tumors occur in 12 per cent. of all white women over forty, while Bayle and Klol make the percentage much larger, even 40 per cent. of women

over 40 years, especially among black women. It is well known that they are much more frequently found in colored women and also at an earlier age, even under 30 years. But colored women are less liable to cancerous affections of the womb and cysts of the ovary and adnexa. All of these facts are important in summing up the symptoms which go to make a diagnosis.

Tumors, whether myoma or fibroma, so long as they are small or favorably located so not to cause irritation and congestion, may not give rise to any symptoms. The severity or amount of disturbance bears no relation to the size of growth. These neoplasms are of slow growth as a rule. In this respect they differ from *soft* tumors of their class, viz., the myxomata or mucous tissue tumors, including the mucous polypi.

As fibroids never appear before puberty, and rarely before the age of 30, there is generally, antedating the appearance, a more or less protracted history of chronic metritis, catarrh of the endometrium, or irregular and profuse menses. This is an important guide to call us to more thorough investigation.

The subjective symptoms are very variable, sometimes few, at other times many, but there are none so uniformly present as to make them diagnostic.

There are two symptoms uniformly present in this class of uterine neoplasms, viz., hemorrhage and pain. Sometimes the former is preceded by gradually increasing frequency of menstruation, the flow becomes more and more profuse with each recurring period, and the intervals between are steadily shortened, until there is established complete irregularity with metrorrhagia. It occurs again, but very rarely, that there is a sudden and great loss of blood, coming with a gush, and often so as to greatly reduce the patient. And this may recur irregularly but always suddenly. This hemorrhage may be distinguished from that of malignant or soft polypoid growths in that it

is usually unattended at first by serous and slimy leucorrhœal discharge, being a brighter, fresher blood, and also coming more in paroxysms with free intervals. The more severe these attacks the greater the certainty of a submucous growth. The interstitial tumors have a somewhat lesser hemorrhage; while the sub-peritoneal fibroids or myomata are seldom attended by this loss; only when the origin of the pedicle has pushed toward the uterine mucosa. We make this point, then, that the amount and character of the hemorrhage is symptomatic of the location of the fibroid.

There is one form of interstitial myomata, the large, soft variety, where the growth is diffuse and the mucosa extremely vascular. In this form there is sudden and terrible hemorrhage, rapidly exsanguinating the patient. The bleeding recurs, and more frequently. The menorrhagia changes to a metrorrhagia, irregular but frequent. The patient becomes anæmic. The anæmia is distinguished from that of the cancerous cachexia, as there is not the peculiar waxy pallor and other constitutional indications.

Such a type of hemorrhage is more like that from malignant uterine tumors. Yet in the intraparietal, soft, diffuse fibroid, which is very difficult to diagnosticate, there is no local discoverable cause to account for it, while a local cause is always present in cervical or uterine cancer.

The second symptom, uniformly present, is pain. The severity, continuance, and character of the pain is variable. Small growths have little pain, unless, as in the instance above, their location is a cause of aggravating the serious symptom. Usually pain is in proportion to rapidity of growth and size. Sudden attacks of pain in uterus, persistent in their recurrence, and from no defined cause, starting from the same place and stinging and lancinating in character, are suspicious of uterine neoplasm. The amount of pain is not characteristic of fibroid, to the degree that the hemorrhage is, yet the sub-peritoneal growth prob-

ably gives rise to the greatest distress as it attains such large dimensions. While the tumors are smaller, the pain is corresponding to the pressure, position, and kind of nervous and circulatory disturbance. As the growth enlarges there is a different kind of pain, described as a stretching, dragging sensation. Interstitial or sub-mucous fibroids are more likely to give rise to this symptom. And as these growths continue to enlarge a third kind of pain is noticed. This is a heavy, bearing-down pain with pressure, attended by increased weight and discomfort in the pelvis. In a sub-mucous fibroid, where the cavity of uterus is filled, the pressure sets up labor-like pains of an expulsive character. The growth presses on the os, which often opens and expels it under these muscular contractions. Even enucleation has been produced and the tumor pushed into the vagina, the cervix closing again and pain ceasing. Not so desirable a result occurs when the tumor has a broad and sessile pedicle, in which case the pains increase and demand digital examination by the physician, when through an open os the diagnosis is readily made. In intraparietal growths the pain is not at all characteristic or symptomatic. After a time by their size they cause uterine deviations and pressure. The small, encapsuled interstitial myomata often cause flexions and versions of the uterus. In anteversions from this cause there is great pain from the strangury induced by the increased pressure. As these intramural growths are located in one or the other of the four sides of the uterus, by their growth and size and the attendant morbid development of the uterine tissues, they bring on displacements of a very painful character, according to the location and pressure. Thus you see we may have distressing rectal or vesical symptoms, dysuria, cystitis, strangury, or retention on one side, and constipation, hemorrhoids, or ovarian neuralgia on the other.

In subperitoneal fibroids there is no pain or little pain when they are small. When, however, they are located low

on the body of the uterus or on the cervix there is a pain from the start, and these growths here are more dangerous every way. This is from the confined space and pressure causing the more trouble. When subperitoneal fibroma attain large size the pain becomes a constant symptom. As a true fibroid is hard and may be nodulated this causes irritation and inflammation of the peritoneum. Adhesions occur increasing the pain and drawing. In short, the pain of these tumors is characteristic of all internal abdominal growths. Sometimes not more painful than pregnancy; at others there is a constant, agonizing pain. But the pain from a benign fibroid of any class is quite distinct from that of malignant growths, as will be seen farther on. While a careful study of the variety, course, and degree of suffering from uterine fibroids will aid as a symptom in arriving at a correct opinion, we must admit that they are not distinctly diagnostic. Before leaving this branch of the subject I wish to call attention to one important kind of pain which often arises from small, slow-growing tumors. I have noticed more than a few times in my experience in such cases a line of hysterical symptoms, occurring at the menstrual period with peculiar regularity. The patients were not of hysterical type. The symptoms were recent and unusual. There was more or less of discomfort in the uterus. Palpation was painful after menses, especially, the uterus was sensitive. Parvin says, "Many patients, so affected, are simply called hysterical," because the tumors are still too small to be recognized by palpation, and the uterus may neither be enlarged, displaced, nor otherwise affected. Indeed, no other disease so well deserves the name as this one. Hysteria or pain in the uterus is, in the early stages, the most important, and often almost the only symptom. Be watchful and investigate the cases.

The prominence I have given to the foregoing consideration of the two symptoms of hemorrhage and pain is because reference to the points made will help to classify

and distinguish the other forms of uterine neoplasms. The remaining symptoms developed by myomata of the uterus are variable and not distinctly symptomatic. Simple leucorrhœa at first changes to an albuminous and finally to a muco-purulent discharge. When the latter is observed you may be sure that ulceration has occurred. The leucorrhœa increases with the size of the growth and the greater local congestions of the irritated mucous membrane. The hemorrhage, pain, and leucorrhœa steadily increase the debility of the patient, and bring on a profound anæmia. Then we have a long train of reflex uterine symptoms, headache, nausea, and anorexia, vomiting, pale and coated tongue, cardialgia and palpitation, insomnia, emaciation, nervous twitchings and fainting. These all follow mainly from the loss of blood and pain, and should the myomata be discharged spontaneously, as is sometimes the case, or by surgical interference, the patient at once regains color, flesh, and strength in a remarkable degree. This demonstrates the freedom of the hard fibroids and myomata from any malignant tendency. In these firm and circumscribed growths, including all pediculated or polypoid myomata, the danger is from the above causes only. They are benign and endanger life by secondary conditions. They never infiltrate(?) adjacent tissues or glands. They displace them as they grow. Pressure may cause adhesions by inflammation, but no destructive change of tissues.

The last train of symptoms arises from mechanical pressure. In sub-mucous tumors, including the polypi of all forms, pressure increases local discharges, resulting in increased hemorrhages, muco-purulent discharges, and all the train of vesical and rectal suffering. These are also present with the very large sub-peritoneal myomata, together with varices, cramps, numbness of extremities, hemorrhoids, and œdema of vulva and lower limbs. We have now followed out the whole line of subjective symptoms,

and have noticed that only two are always present, and these are not diagnostic. They are symptomatic, and important as indications. We will now turn to objective symptoms, which are well marked, and their indications, taken with the subjective symptoms, make diagnosis usually easy, except in very complicated cases. In any case having hemorrhage, pain, and the other indications suspicious of uterine growth, it is necessary to make a physical exploration. If the symptoms point toward a mucous or sub-mucous growth, a digital examination should be made.

This will reveal an os more or less open, as showing a pressure from within. Sometimes the polypus is in the vagina, pedicle hanging from os or from within the cervix. Sometimes the tumor can be felt within the os. If the finger can enter and locate the pedicle and its form and size, it is distinctive. If a polypus can be rotated on its vertical axis readily it has a narrow pedicle, otherwise a broad or sessile one. If surface is smooth and soft and easily bleeds, it is a mucous polypus. The degree of softness may verge on to the myxoma or colloid polyp, and only microscopic examination can determine. If the tumor is hardened, round, and smooth, although at times irregular in outline, and insensible to touch, it is fibroid or myoma. The harder the surface, the more likely connective tissue is in excess and it is a fibroid. A myoma is smooth and more regularly round, and a little softer. The softer the tumor and more vascular, the greater the mucous or albuminous discharge as a rule. Where these polypoid growths have grown to the size of a robin's egg and larger, we will find the uterus enlarged, its cavity deeper, and its walls thickened, congestive, and sensitive. If this is the case, with profuse flooding, and we find no tumor near the os, we must dilate the cervix and explore with care the intra-uterine walls. If there is a firm, circumscribed bulging in one of the walls which is thicker than the other, we may find an interstitial fibroid. If it is nearest the mucous surface and growing in the line

of least resistance, it may be enucleated at once and so end the trouble. Always explore for others after finding one. They are found in couples and more. These intra-mural myomata are sometimes found in the cervix. Here they are easily located. They often give rise to very distressing suffering. By their hardness and bulging when small they are easy to determine. But when large the differential diagnosis must be made with care. They greatly complicate and endanger labor at times when present. Fibroma of cervix, or carcinoma, at full term complicating labor, may be known from the natural or œdematous cervix by this diagnostic point: During the interval between the labor pains the fibroma or carcinoma will continue dense and hard, while the natural or œdematous cervix will relax. Many times fibroma or carcinoma reveal their presence *before* labor by pain and hemorrhage.

In interstitial fibroids situated higher up and at the fundus, we need the conjoined use of the sound, with the finger in the anterior fornix to detect thickening or bulging in the posterior wall. The firmness and rounded hardness of the growth can be told from hypertrophy or swelling of the uterine walls. These examinations of conjoined bi-manual and sound will clear up these cases from all simple displacements.

The larger the sub-mucous tumor the deeper the sound will enter the uterine canal, also to nearly the same degree of depth with an interstitial growth. But with sub-serous fibroids the cavity is not enlarged. Large interstitial fibroids by their presence cause more or less hypertrophy of the uterine walls. This is attended by a great enlargement of blood-vessels. On this account we have a very valuable diagnostic symptom. This is a sound like the placental souffle *bruit* which enables us to decide that the tumor is not only interstitial, but also often to decide whether tumor is near the mucous membrane or the serous membrane. By this means of diagnosis it has been able to oper-

ate by enucleation rather than by laparotomy. In using sound we must assure ourselves, by waiting, that there is no pregnancy, for it may be there are both tumor and pregnancy. Usually in sub-mucous and interstitial growths the uterus is low, but in sub-peritoneal fibroids the os is high. If conjoined with this the sound gives a normal uterine cavity and direction, the growth is sub-peritoneal.

This tumor attains the largest size. If it is attached by a long and narrow pedicle we find it very movable. It can be separated from the womb and moved independently of it. If attachment to womb is short and sessile the diagnosis will be more difficult. A fibroid is characterized by hardness. By palpation and bi-manual methods the surface indications can be well made out. It is well defined and solid. If closely attached to uterus it moves as uterus is moved. Percussion gives a perfectly dull sound if intestines do not intervene. Auscultation gives a bruit if pedicle is large, but not if pedicle is small. By bi-manual examination, sub-peritoneal fibroid, uterus moves independently; but with interstitial, uterus and tumor seem one.

By external examination, when there is cystic degeneration in any part of a fibroid tumor there will be fluctuation. This shows it to be a fibro-cystic tumor.

When the sub-peritoneal myomata become large, changes occur in them by degeneration, inflammation, and adhesions, so that difficult questions of differential diagnosis arise. This is a department in itself and does not further come under the scope of this discussion.

There are one or two other forms of neoplastic growth with which we have to deal, which are interesting in themselves and from the new light which has been shed upon them by modern research and the microscope. While not usually of individual size to be separated, handled, and examined, it is found they are none the less neoplasms.

They are called by a variety of names, such as sessile, polypoids, fungous vegetations, fungous endometritis, en-

dometritis, hyperplastica, and cauliflower excrescence, but the better name is *adenoma*.

Another class, differing somewhat anatomically from the adenomata, is called a villous and sarcomatous degeneration of the endometrium; or *papillomata*. This last name is histologically descriptive. The symptoms are generally sacral pain, uterine colic, spasmodic pains attended by severe flooding at menstruation, and all the time more or less free water discharge.

These conditions are produced by a hyperplastic thickening of the uterine mucosa, or proliferation of the endometrium. On examination we notice a velvety feeling to the mucous membrane. It is red, covered with sessile, minute, club-shaped polypi, from the size of a millet-seed to that of a pea, of spongy consistency, easily torn, and bleeding profusely, generally without sensation. This last symptom is important to differentiate from a diffuse sarcoma, which it resembles at one stage, but which is extremely sore and painful to touch.

In company with this growth we may often find a large mucous polypus or fibroid tumor. The symptoms preceding these cases as they come into our hands give generally an interesting history, which needs to be considered in summing up our case. Adenomata and papillomata follow after chronic endometritis, sub-involution, retroverted uteri, gonorrhœal infection, and neglected cases of laceration of the cervix. These neoplasms may attack the cervix or endometrium. Schroeder has remarked in regard to these cases, and it is an aid in differential diagnosis, "that in his experience malignant diseases of the endometrium are usually found in old maids and sterile women, while malignant diseases of the cervix are almost always found in women who have borne children." And this remark of Schroeder's brings us to consider that adenomata, and to a still greater degree papillomata, lie on the line between benign and malignant growths. So long as these

growths are insulated patches, with free and healthy mucous membrane between, they are most certainly benign.

But when these vegetations grow large and crowd close together, and involve all the mucosa, they not only give rise to a fear that they may be a diffuse sarcoma, but it would not be unnatural to feel that a truly benign growth at the start had degenerated into a sarcoma or carcinoma. This view is held by many able men. Only the microscope can decide these cases. And it requires many cases of mixed histological growths, an expert with the microscope, and many examinations of the tumor, taken from different locations and before degeneration occurs, in order to verify the exact diagnosis.

Whether normal tissue, even in morbid conditions, or neoplasms of normal tissue, may or can degenerate into malignant cancerous conditions, or whether malignant growths are always *de novo*, remains for the microscopist, pathologist, and histologist to determine. There are no symptomatic indications early enough in the cases to be of any service in saving life.

The last tissue changes which are so distinctively symptomatic come too late, though they are truly diagnostic. Goodale sums his up in speaking of this stage of a sarcomatous degeneration of the endometrium, as he terms it. He says: "Its diffuse growth, absence of capsule, friability, placenta-like structure to the feel, and later its excessive fetor, stamp it with an almost unquestionable microscopic individuality."

In closing this paper I would say that when one considers the variety of the benign neoplasms of the uterus and their painful and dangerous effects, it may seem strange that so little that is exact in diagnosis can be learned from a study of the symptomatic indications. Were we alone to depend on subjective symptoms we should continue to grope in the dark. The objective symptoms and physical examinations give very clear data to arrive at certainty in diagnosis. Yet

here we are at fault in those growths and tissue changes which are formed along the boundary of malignant growth. Here only the microscope of an expert histological pathologist can aid us to a true diagnosis. But while we see that symptomatology can only go part way with us, we must not therefore discard her help. Let us more and more study and perfect the system until it shall become all that is possible as an aid in the good work of relieving and curing our suffering mothers and daughters.

NEW REMEDIES IN GYNÆCOLOGY.

BY PHIL. PORTER, M.D.

(Continued from Vol. 10, page 523.)

LEONURUS CARDIACA.—This remedy is recommended in nervous complaints, pains peculiar to females, with morbid nervous excitement. Leonurus has been classed by the "old school" as an emmenagogue, nervine, antispasmodic, and laxative. The late Dr. E. A. Lodge used it with success in amenorrhœa from colds, and regarded it in suppressed lochia as superior to any other remedy. It is also of use in hysteria.

MAGNESIA PHOSPHORICA.—Formula, $\text{MgHPO}_4, 7\text{H}_2\text{O}$.—Among all the remedies recommended by Schüssler few have found more frequent use than magnesium phos. Its indications include all ailments of a spasmodic nature; warmth is soothing; neuralgic cramping pains, worse by motion; colic; spasmodic coughs, worse at night; whooping cough. As a remedy for spasmodic pains it appears that it may be useful in certain forms of dysmenorrhœa. Dr. D. B. Whittier, Fitchburg, Mass., reasoning by induction, has employed it with such success that he characterizes it as "the chief remedy in menstrual colic." As evidence he presents the following:

"Miss S., aged twenty. Nervo-sanguine temperament; menstruated at twelve years of age, and for six years menses were normal; eighteen months ago had suppression from a cold, when pelvic inflammation ensued, and was aggravated by a fall downstairs four months after; during the skating craze was in daily attendance at the rink. For eighteen months she has had menstrual colic; periods regular, and flow normal; severe cramp pains in hypogastrium, causing the patient to toss and roll about upon the bed, and the constant application of hot fomentations for twenty-four hours; had pains extending down the legs; heat in the back; and in the menstrual intervals, dragging and tired feelings in the pelvis. Physical signs by touch were prolapsus uteri; by speculum, endocervicitis, and cervical erosion; by the sound, unobstructed canal, measurement of womb two and a half inches. Bland albuminous leucorrhœa has increased for the last six months.

"Applied glycerole of flu. ext. of belladonna, twenty drops to the ounce, and prescribed mag. phos. 6x, three doses daily. Five days after, the menses appeared, and surprised both patient and friends by the diminished pain, quite one-half, so that she had comparative comfort, and the attendants were relieved of the constant application of fomentations.

"The amelioration of this period was followed by relief of backache, and a very noticeable lessening of the leucorrhœa, and has remained so since. Relapses occurred in this case, when the periods would recur in the usual severity. Other remedies were given for a time in the hope of a more speedy cure, but were less satisfactory than the mag. phos., which was again administered morning and night. Occasional applications of a solution of chloride of gold and sodium was made to the cervical canal. The patient is now well after five months' treatment."

Dr. Hite in the *Eclectic Medical Journal* gives a number of cases of uterine and menstrual colic and ovarian neural-

gia cured with magnesium phos. Dr. Rosas in the *Leipsiger Populäre Zeitschrift für Homœopathie* extols the remedy also for eclampsia and spasms of the parturient woman.

ONOSMODIUM VIRGINIANUM.—The provings of this drug instituted by Dr. W.E. Green, Little Rock, Ark., developed a number of symptoms that should have received, ere this, some verifications. In the female sexual organs we have :

Severe uterine pains. Bearing-down pains in the uterine region. Uterine cramps "like those produced by taking cold during menstruation." Soreness in uterine region increased by external pressure, and by the pressure of the clothing; had to remove the corset. Old uterine and ovarian pains that had not been felt for years re-excited. Dull, heavy aching, and slowly pulsating pains in the ovaries. Pains begin in one ovary and then pass over to the other, leaving a soreness that lasts until the pains return. Severe pain in the ovaries, increased by pressure. Old ovarian and uterine pains, at first entirely relieved, subsequently greatly aggravated. Sexual desire completely destroyed. Uterine pains better when undressed and when lying upon the back. Constant feeling as though the menses would appear. Menstruation, natural in character, appeared four days early, and lasted too long. The next two menstrual periods were anticipating and profuse. Light yellowish, slightly offensive, and excoriating leucorrhœa; profuse, running down the legs. Itching of the vulva, aggravated by scratching and by contact of the leucorrhœal discharge.

Abdomen.—Bloated feeling and distension of the abdomen, relieved by removing the clothing. Pains in the lower part of the abdomen, relieved when undressed, or by lying upon the back. Colic relieved by bending backward. Colicky feeling in the lower portion of the abdomen, like when drinking iced water. Constant feeling as though diarrhœa would come on. Abdomen feels bloated and distended.

Neck and Back.—Pain in the neck, running back from the forehead. Dull aching pain in the neck. Pain in the back, very low down. Pain in the small of the back on awakening in the morning, passing away about noon. Bearing-down pains in the lumbar region. Dull, aching pain in the lumbar region.

Aggravations.—Generally worse from motion or jar; worse from pressure or tightness of clothing.

Ameliorations.—Better when quiet, when lying down upon the back, from sleeping, when undressed, and from cold drinks and eating.

Generalities.—Great muscular prostration and tired feeling over the entire body. She feels like she had just gotten up from a spell of severe sickness. The least exertion causes a general tremulousness. Nervous, trembling feeling as if from hunger. Extremely nervous and shaky, which physically and mentally unfits her for any duty. The muscles feel unsteady and treacherous, as though you dare not trust them to move. Great inclination to move around with no object in view; will lie down for a few moments, and without reason will get up and go somewhere else. Will take a seat, and in a few moment, without thinking, will move to another place. Will start to get some object, say a book, but before the thing desired is obtained, will forget and start to get something else. There is no relief or aggravation of the symptoms resulting from this moving about. It is a simple desire to change position without definite cause or reason. These symptoms appeared early. Later, all provers had the desire to lie down and be quiet, with a drowsy, sleeping feeling. Sensation as if a chill would come on. Tired, aching, stretching, gaping, disagreeable feeling. In going up-stairs she was afraid to look down lest she might fall. When walking by a fire she felt afraid that she might fall into it, and in spite of all her will-power did actually stagger into the fire. Flushed face, increased by the least motion or excitement. Flushed feel-

ing over the whole body. Feels as though something terrible is going to happen and that she is powerless to prevent it. All sensations and pains are worse in the left side.

PIPER METHYSTICUM.—*Synonym*, *Macropiper Methysticum*; *Natural Order*, *Piperaceæ*; *Common Names*, Kava Kava, Ava-Ava, Kawa Kawa, Yaguona. This exotic drug from the island of Polynesia promises to become a useful addition to our *matéria medica* when its range of usefulness shall be fully ascertained through clinical application.

The symptoms produced by Piper M., when taken in appreciable doses, is a peculiar sensation about the upper part of the body. The vessels of neck and base of brain feel full, as if circulation had been cut off with a cord; whole back of head, neck, and cerebellum feel congested, sore inside and tender to outside pressure; these parts feel as if double or treble their natural size. After business anxieties, pain in middle of forehead, extending around sides to occiput; all the cerebellum and medulla feel compressed, especially from before backward, causing great restlessness; feeling as though he must move, or head and neck would be compressed to death. This constriction also extending to chest and stomach. Pains in head relieved temporarily by turning the mind to another topic. Soreness in back about second dorsal vertebra. Right arm especially affected. Trembling sensation in bowels and lower extremities. Better in open air and when moving.

Pain in back of head and spine, and relief from all sufferings temporarily by change (mental or physical), slight excitement, or diversion of the mind to some other topic. (Raue.)

Dr. T. F. Allen has given us an extensive pathogenesis of Piper methysticum, but clinical reports as to its efficacy are very few in number. The chronic use of it is said to

produce a scaly affection of the skin. Some observers deny it any etiological connection with skin diseases occurring on these groups of islands with the use of kava, and consider it a true ichthyosis which occurs also in places where the kava is not used. Others again call it pityriasis universalis simplex.

An important use of kava is illustrated in the following narrative: "On the 29th of June, 1874, the despatch boat Hermit was lost in front of the Islands of Wallis. Mr. Dupouy, the physician of the boat, found himself on a small island, called Nukutea, deprived of his pharmacy, which the sea had washed away, and with many of his men suffering with urethritis contracted in Tahiti. The queen of this hospitable island sent him the kava, and from the start the curative effects were marvelous." "In fact," says F  ris, of Brest, "it has, above other blennostatic agents, the following advantages: It does not produce diarrh  a or constipation; it is pleasant to take; it increases the appetite; and, finally, it brings about a cure, either of acute or chronic cases, with extraordinary rapidity. The anti-catarrhal action seems to be due to a resinous substance, and the diuretic to the *kavama*, a neutral crystalloid discovered by Cuzent." *

In this connection we have the thesis of Dr. Dupuy in *La Tribune M  dicale* on "Kava-kava and its Blennostatic Properties." He concludes as follows as to its essential therapeutic properties:

1. Kava-kava is a sialogogue.
2. Its action on the stomach is that of a bitter tonic; it improves the appetite without producing either diarrh  a or constipation, and perhaps acts as a prophylactic to catarrhal affections of the upper part of the digestive canal. Its taste is agreeable.
3. It exerts a special stimulating effect on the central

* Edward Formias, M.D., Philadelphia, Exotic Drugs for Provings, Penn. Hom. Med. Society.

nervous system; this stimulation differs essentially from alcoholic intoxication, and is called by Dr. Dupuy kavaic stimulation.

4. It is not a sudorific.

5. It increases very markedly the excretion of water in the urine, and may be classed among the most efficacious of diuretics.

6. It does not produce priapism, as has been stated, but, on the contrary, it prevents it.

7. It is endowed with remarkable blennostatic properties, which manifest themselves very promptly. A chronic urethral discharge is first rendered more profuse, and is then promptly cured.

8. It is very efficacious in cases of acute urethritis or vaginitis, calming the inflammatory condition, controlling the pain during micturition, and suppressing the mucopurulent discharge from the urethro-vesical mucous membrane.

In the *Investigator*, Dr. Wolff reports excellent results from its use upon himself in chronic cystitis, with fetid urine of a dirty color, with a crystalline sediment on the bottom and sides of the vessel; but especially depositing a stringy, gelatinous mass, very adherent. The above cleared up under kava-kava, but the urine became sour, greenish in appearance, with variegated pellicle floating upon the surface and a deposit of very fine sand, which may be mingled with the above gelatinous mass. Later the urine became frothy, and so remained for a long time. Under the continued use of the *S*, strangury resulted, followed later by thick, lumpy mucous discharges, obstructing the passage of the urine. On stopping the remedy these symptoms gradually disappeared, the pellicle alone being present some ten days later. Upon a return of the old symptoms a month or two later, brachyglottis seemed to follow well. In the report of a case of metritis, by Dr. Hiller, which had been previously under allopathic treatment for six weeks, the

patient complained of "a sharp pain from right ovary through to back, with tenderness of abdomen to touch and cold extremities." Patient of a dark complexion and constipated habit. Pains were aggravated and rendered unbearable after cham. S, but were promptly relieved by K. kava S in water. (From the above, this drug may be an addition to the antidotes of cham.) Dr. H. also reports its successful employment in the case of "a lady suffering from nervousness and tremulous weakness as a sequel of pneumonia. She was fearful; short-breathed on ascending; loss of appetite and impaired digestion; complained of pain under right shoulder-blade and through right chest, directly down right side and hip, with extreme weakness in loins." She received ten drops of fluid extract four times a day. Improvement commenced immediately, and at the end of eight weeks the number of drops was reduced to four; was apparently perfectly well at the end of ten or twelve days. In the same number of the *Investigator* as that in which Dr. Wolff's article occurs, Dr. Skinner of Liverpool contributes some valuable verifications of the mental symptoms of K. kava. These are: "Sleeplessness and restlessness, compelling change of position (ars. and rhus)." The pains were "agonizing (acon.), with tossing, twisting, and writhing, and were temporarily relieved by the attention being diverted." Good results from both S and sooth attenuation. From Dr. Hiller's observations it seems to affect the right side especially.

SOCIETY MEETINGS.

The Massachusetts Surgical and Gynæcological Society held its annual meeting in Boston, Wednesday afternoon, December 12, 1888, President Alonzo Boothby, M.D., in the chair. Five applicants were recommended and elected to membership, viz.:

C. L. Cleveland, M.D., of Cleveland, Ohio; G. W. Worcester, M.D., of Newburyport, Mass.; E. L. Mellus, M.D., of Worcester,

Mass.; C. M. Nordstrom, M.D., of Malden, Mass.; E. A. Sears, M.D., of Malden.

Officers for the ensuing year were elected as follows: President, L. A. Phillips, M.D., of Boston. First Vice-president, C. R. Brown, M.D., of Lynn. Second Vice-president, C. M. Fuller, M.D., of Boston. Secretary, G. R. Southwick, M.D., 136 Boylston Street, Boston. Treasurer, J. H. Sherman, M.D., of South Boston.

The following papers were read and discussed, and are sent for publication:

Presidents' Address, by A. Boothby, M.D.; Report on Progress in Surgery, by J. K. Warren, M.D.; Diseases of the Rectum, by F. W. Halsey, M.D.; Clinical Observations in regard to some Hystero-Neuroses, by F. C. Richardson, M.D.; Clinical Cases, (a) Inversion of the Uterus, and (b) Uterine Hydatids, by J. H. Sherman, M.D.

By invitation of the president, Dr. C. L. Cleveland, of Cleveland, Ohio, offered some suggestions regarding the study and systematic use of therapeutics as applied to surgery and gynecology.

The meeting was fully attended, and highly enjoyed by all present.

I. A. PHILLIPS, Secretary.

ADDRESS BY A. BOOTHBY, M.D.

As the president of this society it becomes my duty to present to you an address. For such a paper as this I trust you will pardon me if I go somewhat outside the "beaten path," which consists in praising the society, rehearsing the wonderful things we have done, and extolling our principles, and present some thoughts as to the aims of the society, the position we should occupy in relation to the community and the great profession of medicine. As the name, "Surgical & Gynecological Society," implies, our papers and discussions are devoted to a presentation of matters pertaining to surgery and diseases of women; but I do not understand by this that many claim to give exclusive attention to these two departments of medicine, nor that all give special attention to them, but that we are a body of physicians seeking for information, and we hope to have presented the more accurate knowledge of the specialist along with the difficulties and needs as well as the experience of the general practitioner.

One of the greatest advances of modern times has been made in surgery within the past few years. Whatever theories we may hold as to the scientific principles underlying or involved in the present method of treatment of wounds, we all unhesitatingly admit the remarkable progress that has been made. The improvement has

been so marked that it has arrested the attention of everybody, the laity as well as the profession. It has been brought about through a certain theory as to the cause of inflammation, and upon this theory a specific course of treatment has been formulated and carried out, and these results have followed. Before this the surgeon stood aghast at the necessity of opening the knee-joint ; now he opens it with scarcely a fear. Then, to remove an ovarian tumor was a very dangerous operation ; now, a patient never dies except there are very grave complications in connection with the tumor, or the existence of a serious constitutional disease. Then, the cranial cavity was a sacred place, never to be entered except in the direst extremity ; now, the brain is operated upon freely. The same is true all along the line. With these facts before us, and while availing ourselves of the large part of the improvement in treatment which has grown out of it, can we discard the theory without very careful study, with an earnest desire to get the truth, whether it conflict with our previously conceived ideas or not ? And just here lies the difficulty, just here is the great hindrance to all progress. So many study to find out what they can to confirm them in the position they have taken, but willfully close their eyes to facts they do not want to admit.

In the name of this society there is no sectarian title, and I trust our essays and discussions will be conducted upon the sole idea of getting at the truth, or getting in line with the truth, and approaching it as nearly as possible without regard to school or pathy.

A great majority of the evidence that comes to us from scientific workers in bacteriology goes to show that certain micro-organisms have to do directly or indirectly with the production of inflammation. Whether the disturbance is from the presence of these micro-organisms themselves, or whether they develop a poison, a ptomaine, that produces the diseased condition, may be an open question, one that can be left for the present, while we go on to determine by careful investigation how far and by what means we may render them, or the poison they produce, inert.

It is possible for the members of this society to help work out this problem. This question is a fundamental one to the surgeon and operative gynecologist. It is one that has not been satisfactorily worked out as yet.

It is generally admitted that the germs of inflammation may come in contact with a wound from the air, from the operator and his assistants, from instruments or applications, or from the surface of the patient to be operated upon. Different methods have been adopted for rendering aseptic the air and everything else that comes in contact with the wound, while the patient, and especially the field of operation, is thoroughly cleansed. And all of the

methods have been more or less successful. But we have to admit that they are not yet perfect, for there is an occasional failure. It is our duty, and it is our privilege, to try to improve upon what has already been done in this direction. Then there is the possibility of a septic poison existing in the system of the patient and which may be brought to the wound through the circulation. Antiseptics and antiseptic methods fail us here. Is there any way of correcting this condition? Is there any way of determining with certainty when this condition exists, so as to avoid operating until the general infection has been corrected? This seems to be the most difficult part of the subject, and the one that has been too much neglected.

There is a broader application of the principles underlying the germ theory. In our large cities one of the most important questions of the day is how to keep contagious and infectious diseases from spreading and producing epidemics that sweep through the cities and towns like a whirlwind, causing great loss of life and leaving ruin and suffering behind. When sanitary science is fully worked out, it will be found to have received its greatest help from the antiseptic methods. In fact, I believe that there will be nothing worthy to be called sanitary science till the germ theory has become thoroughly understood and fully adopted. Then a scourge like the one at Jacksonville could not occur without gross neglect or ignorance on the part of city officials and city and state boards of health. But if it did occur, public opinion would hold them responsible and guilty of a great crime.

What ought to be done, and what we, as a society that has to do with the question of how to prevent or lessen the amount of disease, should seek to have done is, that our city should have a board of health competent to deal with this matter.

Who is there that has studied this question, and has watched the progress that has been made under the germ theory, and has seen the results that have been obtained in the prevention of diseases that come to the surgeon, who does not believe that the death-rate of Boston might be reduced very much below what it is now? Let us put before our city government such strong reasons for our belief in proper sanitary measures that they will be ready to appropriate sufficient money to carry on all necessary investigations and improvements, and let us demand that a board of health competent to carry out this work be appointed. Let us demand that we have officers, who will not order the gutter pipes opened into the sewer without the possibility of efficient traps, so that the sewer-gas escapes just at the side of the window of our sleeping-room, or that would water our streets with a corrosive sublimate solution which, if strong enough to have the least particle of effect as a disinfectant, would soon fill our streets with a substance in a very fine powder

and would be blown about into our food and drink, into our nose and mouth, producing disease and death.

The whole is always more than a part. We are surgeons for the purpose of developing this department of medicine. Surgery is only a branch. The physician represents the whole. It is the highest duty of a physician to prevent pain, suffering, and death.

It has been pretty conclusively shown that certain diseases depend upon micro-organisms as a cause, and this list has been extending. Who can tell where it will end? But if a disease is caused by germs it is probable that it can be prevented. The germs may be kept from entering the system or a part of it. We believe this has been done in some cases? May it not be done in many more? In fact, may it not be done in all so-called zymotic diseases? It is for us to try and help work out some of these problems. Tuberculosis is believed to be caused by the tuberculous bacilli. We must endeavor to ascertain how these micro-organisms get into the system, and how far they can be kept away or rendered harmless.

But, what is more to our purpose, if tuberculosis is caused by bacilli, may not cancer be caused by similar bacilli? A great deal of our surgery is done to cure or palliate this fearful disease. Is it not possible that our Creator has provided a way for preventing it? If so, can we rest easy until we have found it, when we see its victims falling on every side?

Every gynecologist must frequently have sat in his office well into the night pondering the subject and asking the question, "Why is it that so many women are obliged to come to me for treatment?" He may not be able to answer it; in fact he is not able to answer it fully. But he does not believe it ought to be so to such an extent. While the fairer and gentler sex must endure much in bearing the burden of motherhood, we can not see, we do not believe that it necessarily brings so many ills. To the gynecologist comes with tremendous force and with a peculiar significance the consideration of the great social problem. We owe it to them to do the best we can to solve this problem, and to stand faithfully and with boldness for reforms that shall bring relief.

We are frequently consulted by parents in regard to the various diseases of children and young people. There is too much disease and too great a mortality among school-children. The age at which children should commence to go to school, and the number of hours they should devote to study, the amount and kind of recreation they should have, the number of hours they should be in bed, and how their sleeping-rooms should be ventilated, as well as the amount and kind of food best adapted for a young

and growing child, are matters of great importance. The physician and the specialist have important work to do in this field.

Perhaps in no one particular is there a greater deficiency, and where effort for improvement is more imperatively demanded, than in our *materia medica* in its application to surgical and gynæcological diseases. Prof. Conrad Wesselhoeft and those working with him have shown us how unreliable a large part of our *materia medica* is in its application to ordinary diseases, but when we come to apply it to these specialties we find it still less satisfactory.

But while there are many diseases which are treated by the surgeon or gynæcologist which require only internal medication, and many others that are benefited by it, and while nearly all receive more or less medication, we have a great many that must be operated upon and diseased parts or abnormal growths removed.

It is oftentimes necessary to prepare patients for an operation by mild cathartics or enemas. Ether is a powerful drug, and we give it by inhalation in the form of a vapor till the patient is unconscious, and we keep him under it for a long time.

All these things are right and proper, and no one disputes it. To my mind, the absolute demonstration of the fact that a fatty tumor or a wen on the surface of the body can not be removed or in the least affected by internal medicines is presumptive evidence that other abnormal conditions that are not so readily detected may not be cured by medicines, however strong or attenuated you give them. It is possible, then, that there are incurable diseases which do not tend to destroy life, as well as many that do destroy life and are beyond the reach of any human skill to arrest in their downward progress. Unfortunately, these cases are frequently accompanied with severe pain. We can not cure them, but must we not relieve their suffering?

The surgeon forcibly attacks the system with his ether, his knife, and his antiseptic, when other means fail him. In other words, he resorts to these measures when he can not cure with drugs. Under just such conditions, that is, where drugs fail, is he not justified in using a cathartic to relieve the overloaded bowels, and an anodyne to sooth the pain of one who is dying of cancer?

I trust that there are members of this society who have the ability and will give the time necessary to increase the efficacy of our *materia medica* by eliminating the errors and adding reliable indications, so that the knife and all adjuvant and palliative measures will be less frequently required.

I have only referred to a few of the many questions to be solved, but I have said enough to draw your attention to the fact

that there is plenty of material for every one to work upon, and I will only add that it is my belief that there is room and opportunity for those who will work hard enough to make a reputation for themselves and do a great deal to relieve suffering humanity.

CLINICAL CASE.*—L. A. P.

Miss E., a school-teacher, about 25 years of age, active, vigorous, and apparently healthy, presented herself for treatment several months ago, and, as was indicated by backache and dragging, bearing-down sensation when on the feet, complete retroversion of the uterus was found by examination. No adhesions had formed, as the fundus was easily lifted from the hollow of the sacrum, where it rested. I learned that she had been under the treatment of a professor of gynecology in an old-school college, who had fitted a pessary which he instructed her to wear for six months. Before this time had expired, the profuse offensive leucorrhœa, and soreness in the vagina, caused her to have the pessary removed, and by the use of injections these symptoms were dissipated; but, as the aforesaid condition proved, the result of this method of treatment had not proved all that was to be desired. As this one difficulty was the only known bar to perfect health, I felt that it was a favorable case for treatment, and supporting the uterus in its proper position by a medicated wool tampon, I gave her *lilium tig.* 3x, hoping to see some of the remarkable effects claimed for it. The relief of symptoms was complete while the tampon remained in place, but returned with its withdrawal. She returned again and again. After two months, conditions were precisely as at first, except that there was less congestion and heaviness in the womb, from the depletion of glyceroles applied. *Aurum chloratum et natronatum* was then substituted for *lilium*, and with like results. During the summer while away from the city she wore a Fowler pessary, but not with the degree of comfort derived from the wool tampons. *Aletris farinosa* and *helonias*, *cimicif. rac.*, and *hydrastis* were also useless.

What should be done? This continuous tamponading may be all right if we could do no better; but it is not a cure, and is not satisfactory to me. I want to do more than patch up and palliate such cases. This is one of the small number of such cases to which I believe Alexander's operation of shortening the round ligaments is applicable, and I propose making this operation about two weeks hence. I am encouraged to do this by my perfect success in a similar case operated upon just a month ago,—no inclination to retroversion, and no untoward symptoms having

* Read before the Boston Gyn. Club.

been developed from the time of operation to the present. The more permanent results are not of course demonstrated in this case, but the experience of many surgeons who have performed this operation is, that if the immediate results are entirely satisfactory there is seldom any after-danger, and almost uniform cure of the displacement has resulted.

AMERICAN INSTITUTE NOTE.—The Bureau of Gynæcology is preparing four papers on Urethritis and Cystitis (in the female), and has selected a member to open the discussion on each paper. The chairman requests a general discussion based on professional experience, and says: "Everything justifies the hope of a full and good report."

The Bureau of Obstetrics is engaged upon the general subject of Puerperal Complications. Several members of the bureau are already at work upon their assigned subdivisions.

The Secretary suggests that papers be completed early and copies made and submitted for examination to those likely to participate in the discussion thereon, thus adding to the interest and profit of the sectional meetings. These copies could then be sent to such journals as their authors might select, thus securing their wider publicity, yet without interfering with the prompt publication of the Transactions.

BOOK REVIEWS.

CYCLOPÆDIA OF OBSTETRICS AND GYNÆCOLOGY. Vol. XI.

Sterility: Developmental Anomalies of the Uterus. By P. MILLER, M.D. **The Menopause.** By E. BÖRNER, M.D. With fifty fine wood-engravings.

Part I. This is undoubtedly the most scientific and practical treatise on Sterility ever published. We all know the importance of the subject, and although having often attained the desired end by either therapeutical or mechanical means, we are still conscious of having failed in many cases where the cause was obscure, so that we are glad to welcome any new light that may dawn upon the etiology which has so long been clouded in mystery. Dr. Miller reaches the root of the matter in a most philosophical and scientific manner; beginning with the general causes of unfruitfulness in the vegetable and animal world, and having traced by analogy with them, he goes on to a statistical analysis, both of which methods are of theoretical if not of practical value. He calls attention to the fact that so little has been done in the domain of pathological anatomy, and suggests further that much might be accomplished by experimentation upon living animals.

Under the head of general causes he mentions the marriage of blood relations, which, however, he does not consider a cause of absolute sterility, for the nobility continually intermarry, and certainly they are not all childless; yet the fact that many families of ancient lineage have died out may have some bearing on the subject. He holds too that bastard marriages, although not without bad results, are not proven to be unfruitful. Many cases in which the cause of sterility seems at first to be attributable to a sexual inharmony, if thoroughly investigated would be found to be due to the impotence of the male; that class to which the term "want of sexual unity" is rightly applied, is rare. From a consideration of the general causes he goes on to those of a more special motive, both constitutional and local, devoting four chapters to the cases in which the fault is assignable to male impotence. He lays little stress on dyspareunia or masturbation, as he thinks the tendency of late has been to make a more intimate relation between them and sterility than can be established by facts. The other portion of the work will not create so general an interest as Part I., however, to the obstetrician it will be particularly valuable, as every form of uterine abnormality is touched upon.

Dr. Börner, the other author, has given us a most excellent treatise on the Menopause, a subject of equal importance with sterility and one in which we are as much in the dark. He makes a careful distinction between the physiological and pathological phenomena of the climacteric, and cites a most interesting series of clinical observations, which can be read with much profit. Dr. Börner has certainly accomplished his aim, to contribute toward the elucidating of a "question which stills remain unsettled," in regard to this critical and troublesome period of woman's sexual life.

A SYSTEM OF OBSTETRICS. By AMERICAN AUTHORS. Edited by COOKE HIRST, M.D. Vol. I. Lea Brothers & Co. Philadelphia.

There is scarcely a subject within the comprehensive range of medicine more deserving of attentive examination than the progress of these new works on obstetrics and gynecology published by Lea Brothers. The first volume of the obstetrical series is not excelled in quality or matter by its associates, the two volumes of Mann's System of Gynecology. The former publications were, like this present number, the spontaneous offering of the profession in America, a work of labor and love. The value of these studies is infinitely increased by the practical work accomplished at the various medical societies during the past year. The system of intercourse and interchange of thought has marked this

year as one full of excellent results, and we are consequently ready to grasp and appreciate publications of the character herein presented.

It is impossible that one person can furnish as complete a treatise on a special subject as can be produced by the accumulated efforts of a number equally as well qualified. Publishers are quick to note the demand of the reading portion of the profession, and as characteristic of business managers hasten to meet the necessity, so that the day has passed when one author can give satisfaction, but now any work to be attractive must be in the form of an encyclopædia. Such is this volume of Hirst's *System of Obstetrics*. It contains articles from the pens of professional writers known to be especially well informed on the topics assigned them, and they were selected with reference to their aptitude for presenting their special subject to the profession, men of advanced thought and ripe experience, whose lives have been devoted to scientific study. American physicians should feel gratified that, with the *American System of Gynecology* and the *American System of Obstetrics*, distinctly American, we have now an opportunity to compare our work with that of Wood's *Cyclopædia of Gynecology and Obstetrics*, which is as conspicuously foreign in its staff of writers as this is American. Without permitting our patriotism to bias our opinion as to the true worth of the two works, we can not but declare in favor of the American system, for not only is it more comprehensive, but it enters more minutely and conscientiously into the various pathological questions, and does not leave the subject with a hasty notice of the treatment. A glance at the two works can not fail to satisfy the profession that this American production is by far the grandest work of its kind, and the possessor of a complete set can not but feel that he has at hand the concentrated accumulation of ages on the subject of diseases of women.

A TEXT-BOOK OF GYNÆCOLOGY, DESIGNED FOR THE STUDENT AND GENERAL PRACTITIONER. By A. C. COWPERTHWAIT, M.D., Ph.D., LL.D., Professor of Materia Medica and Diseases of Women in the Homœopathic Medical Department of the University of Iowa. Published by Gross & Delbridge. Chicago : 533 pages, with 215 illustrations.

It was with unusual pleasure and gratification we announced the advent of this work, and now that it is before us, and we have had an opportunity to examine its contents, we are happy to state that the book is everything we expected, and, not unlike this writer's other publications, fully meets our anticipations. While we congratulate the author upon its admirable features, we are also compelled to notice its defects—defects, however, that are

excusable when we consider that the author's work, in his professional life, has been devoted more to the study of *materia medica* than that of diseases of women. In his preface he states that, as a teacher of gynæcology, he had seriously felt the need of a text-book for students that would cover the entire list of diseases comprehended by the term "gynæcology, together with their homœopathic therapeutics. After long waiting in the hopes that some one better qualified would assume the unenviable task of preparing such a work," he frankly admits that while he had "presented nothing strikingly new or original, he had endeavored to collate only from recognized authorities," etc. Therefore, when we say "defects" we mean that the writer, while furnishing a most excellent work on diseases peculiar to women, also manifests, at different points in the book, a disposition to slight, unconsciously however, a thorough and comprehensive application of the mechanical part of the treatment of the disorder under discussion. Acknowledging, as all of our best authorities do, that in the treatment of gynæcological diseases it is impossible to separate the mechanical from the therapeutical, it seems almost imperative that all writers upon this subject should bring out the most scientific information of each rather than to subordinate one to the other. Although the author has honestly tried to avoid the tone or character of the teacher of *materia medica*, it does now and then intrude itself, but adds rather than detracts from the value of the work. Still he has neglected, in several instances, to give the best or latest thoughts on some of the mechanical treatment.

On the other hand, Professor Cowperthwaite's book will prove a boon to the profession, furnishing as it does a complete treatise on gynæcology. While it is true we have other works in our school of a similar nature, each one comes, as it were, as a representative of a special line of study of the subject rather than as a complete presentation, and although the writer acknowledges that the surgical or mechanical treatment is a "collation," this fact alone does him great credit, as he has most assuredly displayed excellent judgment in separating the wheat from the chaff. There has been, in some of our latest works on gynæcology, too much of the old picture-gallery business, simply to save the publishers the expense and trouble of securing fresh illustrations. With original thought or study there should accompany new cuts. It is refreshing to the eyes of a reviewer to meet new illustrations when examining a new book, and to find that instead of pages of descriptive matter there will be a fresh "cut." Not only does a work profusely illustrated assist in selling it, but it is of more value to the student and physician. Witness the enormous sale of Wyeth's Surgery, put on to the market when it was already overstocked with works on surgery. You will find a copy in the library of

almost every homœopathic physician—that is, those who are termed “book buyers.” It is explained upon no other theory than that of having new and elegant illustrations, which save time and annoyance by relieving the reader of the annoyance of wading through pages of printed matter to comprehend a new operation. When a publisher undertakes to cheapen a medical book, which has for its foundation anatomical and mechanical problems, expense in the direction of illustrations should not be considered. More works on surgery, obstetrics, and gynæcology are sold through the merits of the plates and cuts than on account of the subject-matter they contain. How gratifying, therefore, to find, on examining this work of Professor Cowperthwaite's, that Gross & Delbridge have to a large extent departed from this “penny wise, pound foolish” error, and although they might have gone still further, they are entitled to great credit for the change, and on this account we predict a rapid sale of the first edition.

The perusal of a few pages only of this book will furnish to the reader ample reason and stimulus to make him or her rejoice that so important a trust of an author to give us a work of this character was not confided to less intelligent and skillful hands.

The author has divided his book into sixty-four chapters, carefully completing each subject before considering another, which is more than we can say of some other works on gynæcology. It was especially pleasing to find the writer had not only taken up the subject of diseases of the mammary glands, but he had discussed them in a masterly manner. It must be conceded that this part of the human body should come under the care and treatment of the gynæcologist, and its appearance in this work shows the author so regards it. There might have been more space given to the study of nutritive disturbance of the uterus, and yet, as the book is “for the student and general practitioner,” more than the specialist, this may not be regarded as a fault, and still there is complaint, on the part of the reading element of our school, that in all of the books written for the homœopathic profession there is a disposition to cut short or furnish only a meager report of the etiology and pathology of the disease. It is true, we, as a distinctive school of medicine, have neglected the study of pathology, and have given the time and thought to that of materia medica and therapeutics. Professor Cowperthwaite has set us a good example in the arrangement of his subject-matter and the department of gynæcology can not but appreciate the effort of this writer, as it will assuredly give character to this specialty. There are many things to criticise in that portion devoted to abdominal surgery; the absence of practical matter, when discussing the subject, marks too plainly a want of famil-

ilarity with this class of operations. But in its entirety the work stands first as a representative book of gynæcology in our school. We desire to add our personal congratulations to the author.

CLINICAL LECTURES ON CERTAIN DISEASES OF THE NERVOUS SYSTEM. By PROF. J. M. CHARCOT. Translated by E. P. HURD, M.D. Geo. S. Davis, Detroit, Mich., Publisher.

The name of Prof. Charcot needs no introduction to the profession. His brow is already crowned with the laurels of so many scientific discoveries that he "will ever rank among the immortals of the earth." The translator has given us an able and interesting preface to the work. He speaks of his mind as being "essentially cosmopolitan," and that his ideas "come clothed in just the right words," and certainly we have lost little of this eloquence by a translation.

Five of the eight chapters are devoted to hysteria, in the treatment of which he attaches great importance to isolation. One thing is refreshing,—he says very little upon the action of drugs, but treats of hydro-therapy and electricity in full length. This work is published in the Physicians' Leisure Library, which for convenience of form and cheapness of price is unequaled.

HAY FEVER, OR RHINITIS VASO-MOTORIA PERIODICA, AND ITS CURE. By E. LIPPINCOTT, M.D. Gross & Delbridge, Chicago, Publishers. 80 pages.

We feel justified in saying that this is the best monograph that has even appeared on hay fever. The author has treated his subject thoroughly without being superfluous. It is a work that should commend itself not only to the physician but the laity. Coming as it does from one of our own fraternity, it is not surprising that nearly one-half the entire work is devoted to the homœopathic application of drugs, after a careful study of which no true disciple of Hahnemann should be unequipped to battle with a foe over which we have gained so few victories.

The author is a firm believer in the individualization of his cases, and from the reports (clinical) from his private practice, we should judge, has been unusually successful. There is nothing more interesting to the reader than personal experience from active practice, and we note with pleasure the writer, recognizing this feature too, has adopted the method in his little work, and has furnished considerable material.

Some new remedies are presented for consideration, and clinical experience noted. The little work will meet with favor.

EDITOR'S TABLE.

—A new forcep lithoclast, designed especially for lithotrity in the female, has lately been invented by Dr. Hamon du Fougeray of Mans. "Lithotrity among women has been very much neglected. The reason for this is, that until now no special instrument constructed upon anatomical principles has been made. The forcep lithoclast in question appears to fill the place. The crushing is done in the same way as with the cephalotribe. The fundamental principle of the instrument consists in the arrangement of the blades, which pass in closed through the urethra, which is dilated only eighteen millimetres. There is no chance of incontinence, and the crushing is easily effected.

"The operation consists of four parts : 1, dilation of the urethra to eighteen millimetres ; 2, introduction of the instrument ; 3, searching for and finding the stone.

"The removal is done by the instrument itself, which is withdrawn and reintroduced as many times as is necessary. Boracic irrigation can be used advantageously.

"The instrument is easily managed, and if cutting is indicated, it is well to cut only as far as necessity demands."

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—M. Dr. Decaisne, in an article on dipsomania in women which was delivered before the Medical Congress, Paris, May 22 to 26, from an observation of fifty-four cases, closes with the following conclusion : "Thirty-one of the subjects were first attacked either at the time of the appearance of the menses or at the menopause. In three patients it returned with each pregnancy, disappearing completely after delivery ; with five it lasted only during the first month. In about a quarter of them the cause could be traced to domestic troubles ; in another it was connected with heredity ; in only one was it premonitory of mental disorder. The greater number before their first attack were perfectly sober, and had never made use of intoxicating drinks. All, with the exception of three, gave themselves up exclusively to alcoholic drinks, rum, brandy, and cordials. The duration of the attack and the intervals between them vary ; with eight they occurred two or three times a year and lasted more than a month."

Contrary to other writers, several of them presented phenomena of acute alcoholism. From his own observation Dr. Decaisne concludes that dipsomania in women is more common among those of the better class than the poorer. The only mode of treatment that he places confidence in is isolation of the patient.

—Dr. P. Memire, in the *Gazette de Gynecologie*, calls attention to the fact that many writers on the subject of diabetes omit to mention the ulcerative vulvitis which frequently accompanies it. This does not appear at the onset, but follows the pruritus ; it confines itself to the peri-urethral region and the anterior portion of the vulva over which the urine passes. Diabetes can easily be detected by this vulvitis, for if it were merely inflammatory or blenorrhagic in character other parts would be affected and it would become general very rapidly. If the examination of the urine confirms this diagnosis, treatment should begin at once.

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—REFLEX COUGH.—The *Centralblatt für Klinische Medicin* says a woman thirty-five years old, when four months advanced in her third pregnancy, was attacked with tickling in the throat and hoarseness after taking cold. The usual catarrhal appearances vanished in a fortnight, but an exceedingly tormenting dry, rough cough remained, excited by an almost inexpressible tickling in the larynx. No cause for the cough could be discovered on physical examination of the chest and the larynx, but a large erosion of the cervix uteri was found, together with two small mucous polypi in the cervical canal. The polypi were removed and the cervical canal was penciled with tincture of iodine, and within a few hours the cough ceased. The author thinks that the predisposing cause of this reflex cough was general debility due to pregnancy and leucorrhœa, and that its exciting cause was the polypi, while the occasion of the conveyance of the irritation to the cough center was a previous heightening of its sensitiveness by the laryngeal and tracheal inflammation.

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—Dr. Edward Lang of Vienna reports four cases in which cancer and the lesions of syphilis co-existed in the same individual. He believes that cancer was developed upon a syphilitic foundation, and that the latter is therefore to be regarded as one of the possible, though very rare, exciting cases of carcinoma.

It has been our privilege to be able to trace, in several cases of carcinoma of the uterus, a close relationship between the cancerous disorder and the history of an attack of syphilis in early married life. We pronounce without any hesitancy that there is a condition developed under the influence of syphilis which will always predispose a woman to an attack of carcinomatous degeneration of the uterus or some part of the genital tract. In two cases the cancer manifested its appearance in women between thirty and thirty-five years of age who had not borne children, both having been infected some ten years prior to the attack of

cancer. In the other cases the women had borne children, two having suffered laceration of the cervix. The question of this injury and its relation to the cancer of the cervix of course raised a doubt as to the effect the syphilitic cachexia or condition may have had to render the system susceptible to mal-nutrition of that part. There is no doubt but what a severe attack of syphilis always leaves the body in a condition of depravity. An advanced stage of venereal disease creates a foundation not unlike that of a scorbutic or tuberculous habit—if you please—not to be confounded with a diathesis, however. The remaining cases furnished no history of disturbance during their confinement, but had had syphilis the first year of their married life and suffered several abortions during a period of several years following, but under "continued treatment" they were able to bear children until the cancer made its appearance. All of the patients, it might be of interest to relate, were operated upon in various ways, three having the uterus extirpated through the vagina, but all resulted fatally. A previous history of syphilis should, we think, counter-indicate a major operation of any nature. We do not know of ever having a successful result in any large operation, like laparotomy or hysterectomy, where the patient had syphilis in early life; the experience of other operators may have been different.

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—Experiments recently undertaken by Professor Brouardile of Paris, on the action of arsenic and its relations to the maternal milk, have demonstrated that the milk of the women (wet nurses) "contained a relatively considerable quantity of arsenic, although but two to twelve drops of Fowler's solution (liquor arsenicalis; liquor potassæ arsenitis) were administered during the twenty-four hours. After careful experiments on the female animal as well, he came to the conclusion that arsenic on account of the lactic secretion acting as a ready eliminator by predilection for this drug, should therefore be administered with caution to nursing women.

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—At a recent meeting of the Paris Obstetrical and Gynaecological Society, there was reported a case of the death of a woman, on the table, after the performance of ovariectomy where the surgeon had irrigated the peritoneal cavity. As there had been free hemorrhage from severed omental and pelvic adhesions, the peritoneum was irrigated with about three pints of a one per cent. solution of carbolic acid in boiled distilled water of a temperature of about 98. 6° F. The process occupied between two and three minutes, at the end of which time the breathing sud-

denly became accelerated. It then grew feeble and ceased, the face becoming violaceous, but the heart continued to beat regularly. Artificial respiration, tracheotomy, oxygen by inhalation, applications of the actual cautery to the thorax, frictions, hypodermic injections of ether, electrization of the diaphragm, and an attempt to let blood from the arm, all proved unavailing; after two hours spent in their employment, the woman was indisputably dead. M. Polaillon referred to other instances in which irrigation of the peritoneum had produced such an embarrassment of the respiration that great difficulty had been met with in resuscitating the patients, and like occurrences were alluded to."

The effect of the heat upon the lower surface of the diaphragm and upon the solar plexus was no doubt deleterious. It has been claimed by some operators that the fatal effect of irrigation after laparotomy was due to the solution employed—the carbolic acid wash—rather than reflex inhibition.

* * *

—Organizing obstetrical and gynæcological societies in the larger cities seems to be the prevailing fashion. This step would indicate that there is a growing demand for more knowledge on these branches by the profession, and the organization of special societies for the purpose of developing study in this direction would indicate that our colleges have been and are now somewhat remiss in their work in these chairs. It must be conceded that for the want of more scientific and clinical teaching in these two important branches many of our students and practitioners have gone abroad to complete their studies. Many of the homœopathic colleges have, heretofore, subordinated the interests of these two chairs to that of the others, with great detriment to the study of obstetrics and gynæcology. This lack of appreciation is now being manipulated in the organization of the special societies for the object of further developing knowledge in these two branches.

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—An ingenious operation to restore an inverted uterus was lately performed and by Dr. Mundé. Failing to return the organ in the usual method, he opened the abdomen and made an attempt to dilate the ring at the bottom of the funnel, which was made by the condition of the uterus. This proving a failure, he passed a strong silk thread through the fundus and made an effort to bring, by strong traction, that portion of the uterus up through the constricted part. The tissue was so friable, however, that the thread would tear out. He then amputated the uterus, leaving a small portion of the cervix only, with good recovery.

This method of procedure was, many years ago, resorted to with recovery in one case out of six, and was therefore regarded as almost negative in its practicability for relief in obstinate cases of inversion of the uterus. A practical and ingenious instrument was invented by Dr. Ellis of Detroit, a number of years ago, which was constructed under his supervision, to be employed in reducing an inverted uterus. It consisted of a soft rubber bag about four inches long by one and a half inches in diameter (a closed tube.) Through the center there was a canal which permitted a wire (large as an umbrella brace) to pass, which had on the end a hard rubber cup, just long enough to enclose the projecting portion of the uterus, below the constriction. At the lower end of the wire there was a perforation which allowed two strong strings to pass through, which were fastened to a flat disk or button, that rested against the rubber bag above, and acted as a foundation for counter-pressure, or support for the wire. By drawing on the strings the button was crowded against the bag, which, being inflated, resisted the pressure, and by this means kept up a constant pushing upward against the uterus. The soft rubber bag was just large enough to fill the vagina and to keep "everything drawing," and from personal experience with the instrument can speak of it as the best for restoring an inverted uterus we have ever employed or have seen. While this accident to women is, happily, very rare, still it is well to be prepared to meet the emergency when it does arise, and, if possible, avoid the dangerous operation of laparotomy. However popular this operation may become, it will, nevertheless, always be a dangerous one. In one case where a intra-uterine polypus was mistaken for an inverted uterus, the pressure brought to bear upon the tumor through this bag and cup on the wire completely forced it up within the uterine cavity, and too with but little discomfort to the patient, showing how persistent and powerful was the pressure, the *desideratum* of all appliances employed to overcome the constriction and restore an inverted uterus of long standing. When senile degeneration is at fault, we deplore the use of any mechanical treatment, as it will prove futile in its results.

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—PALPATION OF THE UTERUS MADE EASIER BY EXTENSION OF THE RECTUM.—According to the Vienna correspondent of the *Lancet* for June 2, 1888, a new method for facilitating the palpation of the uterus and the ovaries, in cases where this mode of examination is made difficult by any peculiarity of the internal genital organs or by diseases, has been devised by Dr. Emerich Ullmann, assistant of Professor Albert. At the meeting of the

Vienna Gynæcological Society he suggested the introduction of a colpeurynter containing 200 to 250 cubic centimeters of water into the rectum in cases where palpation of the pelvic organs is impossible under ordinary conditions. By this application of the colpeurynter, as had been proved by Ullmann's experiments made on the cadaver and on living persons, the uterus and the ovaries are raised and brought into an anteverted position, so that, by pressing down the uterus against the touching finger, with the hand resting on the abdomen, it is possible to examine minutely from the vagina both surfaces of the uterus, the ligaments, and the ovaries, if the bladder is emptied.—*Buffalo Med. and Sur. Jour.*

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—Dr. Bantock, at the meeting of the British Gynæcological Society, closed his remarks upon "Electrolysis" with the following words: "I have no confidence in the value of this method; I fail to find evidence sufficient to convince me of its utility, at least to the extent claimed for it by its advocates. While I stand on one side I am content to allow others to follow it up so long as they do so in a scientific spirit, free from mercenary considerations, and when they shall have failed I shall be prepared to take the patient off their hands for the purpose of performing hysterectomy or removing the appendages in suitable cases,—provided the chances of success have not been imperiled,—for I believe these operations will not be done away with, nor we surgeons find that, like Othello, our "occupation's gone."

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—THE FIRST OPERATION ON THE FALLOPIAN TUBE.—The nationality of the first surgeon who performed ovariectomy, and the place where that operation took place, have often been disputed, but now it is practically settled. M. Schlesinger, of St. Petersburg, has discovered that the first case of operation on the Fallopian Tube was performed in 1784 at Sarepta, Astrakhan government, Russia. The case is noted in Dr. Monprofit's "Salpingitis et Ovaritis." A multiparous woman, aged 42, was taken ill after an abortion, and a painful tumor appeared in the right iliac fossa. On February 21, 1784, the operation was undertaken by a Dr. Seydel. An incision was made from the umbilicus to the right abdominal ring, passing over the middle of the tumor. The operator opened the peritoneum with a curved, probe-pointed bistoury. Three veins were tied, the protruding intestines were kept back by a napkin soaked in tepid milk. The tumor was attached by a pedicle to the uterus, and strongly adherent to neighboring structures. The operator carefully ex-

amined its relations, and discovered that the ovary was distinct, the tumor being clearly tubal. "*Quâ quidem investigatione certo et indubitato cognovi tumoris hujus sedem non ovarium fuisse sed tubam.*" As it could not be removed it was laid open, washed out with a decoction of bark mixed with a solution of myrrh, and then stuffed with charpie soaked in balsam of Arceus. To prevent the intestines from adhering to the parietal peritoneum pieces of linen, soaked in oil of roses, were laid over them. The abdominal wound was dressed with linen supported by a plaster; later on sutures (*sutura cruenta*) were applied. Drainage by means of a silver tube did not answer, so the operator aspirated, by suction with his mouth, the purulent fluid which collected in the cavity of the dilated tube. This was done four times a day, and the dressings were changed on every occasion. There was fever for a week, but in a fortnight's time the discharge ceased and the wound began to close, the patient recovering completely. At the end of two years Dr. Seydel heard from his patient; she was in perfect health. The operator was decidedly before his time.

ORIGINAL TRANSLATIONS.

TREATMENT OF CHILDREN'S TEETH, by Cravens.—Translated for the HOMŒOPATHIC JOURNAL OF OBSTETRICS.—Children under three years of age are not taken to a dentist, but to the family doctor. When the dentist is asked for his advice, it is his duty to impress upon his patient the importance of preserving decayed teeth as long as possible. There are several reasons for preserving these organs until the second teeth are ready to appear. The first teeth, always regular in their distribution, come in groups, and the appearance of several groups is an indication that determines the approximate age of the patient, the time of development of certain internal organs, the stomach particularly, and from which should be determined the essential regimen for the further development of the organism. This indication is clear enough for any intelligent dentist to profit by it. With adults the masseters are the most powerful muscles; they are capable of sustaining the suspended weight of the body or even more; but with children the power of these muscles is not proportionate, so that often the mastication of solid or fibrous food would be extremely difficult, if not impossible, were it not for the presence of certain sharp tubercles that strengthen the teeth and serve to crush early and quickly substances that otherwise would pass into the stomach without being subjected to the action of the saliva.

These milk-teeth that separate the food with so much care are accompanied by a stomach of very limited digestion. In this connection, decayed teeth, recently cut, present some analogy to the third period of mechanical abrasion so frequent among the old, and which has been compared to second childhood because the sharp edges of worn teeth permit old people to chew their food.

The sharp-pointed edges which a child's incisors present when first cut possess an astonishing power of penetration, but as a child grows older the masseters become stronger, and the sharp points disappear, leaving a smooth edge that is better adapted to an older child. Adult teeth are one-third to one-half longer than milk-teeth, and require on account of their position an alveolar arch nearly twice as large.

The development of the arch usually begins toward the sixth year, and takes nearly six months. Sometimes it is found in children six years old that the permanent under-teeth pierce the gum back of the decayed incisors and affect the movement of the tongue. Six months later the lower side-teeth appear in the same manner as the central ones, and seem to be incapable of ever taking their normal position in the jaw. It is a frequent error at this period to extract these decayed incisors prematurely; while they remain sound, it is hoped that the arch will increase to the size suitable to contain the new teeth. Nothing is to be done but wait. The crown and roots of the milk-teeth seem to act as levers and wedges to assist in the growth of the jaw to the desired size. The tongue also may take an active part in influencing the teeth. It is also necessary to preserve these decayed teeth as long as there is need of space, because the reabsorption of their roots is accompanied by inflammation and by a vascularity that aids the nutrition of the maxillary bones, and consequently assists in the growth of the arch. We should then as far as possible fill all the cavities of the milk-teeth in order to avoid the increase of decay which would necessitate. Even those deprived of pulp should be preserved in order that the absorption may not be interfered with, since this process facilitates the dilatation of the alveolar arch. There are also good mechanical reasons for preserving decayed teeth. They prevent the six-year molars, particularly the under ones, from leaning forward and taking the place intended for the bicuspid. Finally, their presence is needed to preserve the articular surfaces for the proper mastication of food that is as essential for children as adults.—*Paris Médicale*.

INFECTION OF FŒTUS THROUGH PLACENTA.—THE precise manner in which the fœtus is infected by a disease which

has attacked the mother has often been disputed. Small-pox, tuberculosis, and syphilis may infect the foetus. If these diseases depend on micro-organisms, these germs must pass through the placenta; if so, the placenta is not a filter which arrests all solid or noxious bodies, as an old theory supposes. If it be a filter, how is it that, as experience has proved, it does not always let the same micro-organism pass? This is the case with carbon in rabbits. And how is it that the placenta always gives transit, on the other hand, to certain specific micro-organisms, as in the case of chicken-cholera? These questions have been propounded in the *Archives de Tocologie* for August. They appear to be solved by certain experiments conducted by M. Malvoz, of Liège, recapitulated in that periodical. M. Malvoz contends that micro-organisms only clear the placenta barrier and enter the foetus when the placenta itself presents pathological changes in its chorionic villi, changes generally due to the micro-organisms themselves. Thus Malvoz injected into the blood of pregnant rabbits emulsions of Indian ink, an inert substance, and into others solutions containing non-pathogenic bacilli. In no case were any granules of the ink or any bacilli found in the foetus, and in all far less of the infected substances were detected in the placenta than in the liver of the mother. After similar infections with bacillus anthracis, the tissues of 32 foetuses were subjected to cultivation, but, in 163 tubes of cultivating fluid, only 4 showed the carbon bacillus. Lastly, M. Malvoz inoculated pregnant rabbits with chicken-cholera. In every case the specific bacillus was found in the foetal tissues. On examining the placentæ in the latter case, they were invariably found to be diseased; in the carbon experiments the placentæ were but rarely diseased; in the Indian ink and non-pathogenic bacilli cases the placenta was never diseased. The placenta was diseased in all the few cases where the carbon bacillus infected the foetus. The germs were found abundantly in hemorrhagic areas disseminated over the placenta. Clinically, placental lesions are found in syphilis and small-pox, diseases often communicated to the foetus. Thus it would appear that the placenta allows the transit to the foetus of those micro-organisms only which have the property of first setting up morbid changes in its own substance. *British Med. Journal.*

[NOTE.—If the demonstrations of Professor Ercaloni and the deductions derived therefrom are to be accepted, we can not reconcile the above report and arguments to the advanced study of the human placenta of to-day. By adhering to the old theories we, as gynæcologists, can not explain many of the changes of the uterogestation period, but on the other hand if we accept the truths it not only affords us a clearer knowledge of many reproductive proc-

esses, but also provides a solution to some of the much-vexed pathological questions which under the old regimen of study have been and are still surrounded by hypothetical theories that neither anatomy nor physiology is enabled to clear up.] P.

 ABSTRACTS.

INTRA-UTERINE MEDICATION.—By ROBERT BELL, M.D., F.F. P.S.—From the *British Gynaecological Journal*.—My feeling is that the uterus in a very large majority of cases is the *fons et origo mali* in a great many of the various affections to which the tubes and ovaries are liable, and therefore through its medium we have it in our power not only to avert such diseases, but to arrest them when they are making progress, and even cure them when they have become established. In flexions, also, I hold we are too liable to attach undue importance to the so-called supports of the organ. It must not be inferred, however, that I do not recognize the great utility of some of these, amongst which I would enumerate the sacro-uterine ligaments, the vagina, and in relation to it, the perineum; but when we come to speak of the broad and round ligaments I must express my doubts. My conviction is, we do not sufficiently recognize the importance of an intact vagina and the normally rigid condition of the uterus itself, its comparatively light weight, and its tubular formation. It is held by some eminent authorities that uterine engorgement is not a necessary result of displacements, especially flexions.

My first question, then, is, what is the best application, as a rule, to employ in intra-uterine medication? Apostoli uses electricity, but that I merely refer to, as I can see no advantage it possesses. Moreover, none of his apostles seems to have any idea how it acts, or which pole should be inserted in different circumstances. My impression is that the effect is very similar to that produced by other applications, viz, a stimulus to the muscular fibers of the uterine walls, causing them to spasmodically contract and thus expel the contents of the surcharged veins and sinuses. I have treated over 2000 cases of endometritis, and I flatter myself the results will compare favorably with those of Apostoli.

It will be quite unnecessary for me to refer to the various medicaments which have been and are in vogue, for the purpose of treating the endometrium. So far as I am able to judge, that which yields the best results is the iodised phenol, the proportions being 320 grains of iodine dissolved in 8 ounces of liquefied

carbolic acid. This preparation possesses many advantages. It is aseptic and antiseptic in the highest degree, thus its employment is not attended with any of the dangers of Apostoli's appliances, and it yields equally good results.

Secondly, the carbolic acid exercises a powerful anodyne effect on the endometrium; thus the pain produced by the application soon subsides; and thirdly, it possesses powerful alterative properties.

The first class of cases that I will take up is that of endometritis, which, as we know, is the source of so much misery, and I am convinced is also the factor of those inflammatory diseases which affect the fallopian tubes; and not only these, but through the lymphatic connection with the ovaries it may in all probability set up disease in these also. It goes without saying that the ovaries in a very large majority of cases of endometritis do suffer from inflammation in consequence of the serious congestion which follows in the wake of the primary affection of the uterus. In proof of this, I may state that I have frequently observed cases of salpingitis get completely well under the treatment of endometritis, and also it has been my good fortune to note the steady decrease and complete disappearance of oöphoritis under the same circumstances. The frequent, nay almost constant, presence of ovarian hyperæsthesia in endometritis points conclusively to the fact that a morbid condition of the ovaries very frequently depends solely upon a diseased condition of the uterus, and the disappearance of the oöphoritis simultaneously with the endometritis puts this beyond all doubt. While on this subject it is worthy of note that the pain produced by an application to the endometrium in these circumstances is referred by the patient more to the site of the ovaries than to the uterus itself.

I will now proceed to speak of intra-uterine medication in a class of cases where it is not usually employed, but where I have found it very useful, this being due to the fact that displacements are invariably associated with a softened condition of the uterine walls, resulting from a congestive condition of the parts. And I may here be permitted to remark that though not in every case successful, the removal of the flaccid condition of the uterine walls, which so uniformly prevails in flexions, has in a very large majority of instances done more in my hands to remove the displacement and give a permanency of relief than that obtained by the employment of any variety of pessary that I am acquainted with. It will be obvious to any unprejudiced mind that the result will be much more satisfactory if, while we restore the flexed organ to its normal position and at the same time employ means to give tone to the uterine walls, we will obtain better results than if we simply keep the debilitated organ in position by a pessary. In

the former case we not only relieve the uterine engorgement, but also the concomitant constitutional symptoms, and thus improve the general health of the patient, whereas in the latter the health of the individual remains very much in *statu quo*, from the fact that the atonic and hypertrophied condition of the uterus remains, or at all events disappears very slowly.

It must not be inferred, however, from what I have said that I discard the employment of pessaries altogether in the treatment of flexions, for in many instances they prove a most useful auxiliary in the early stages of treatment. My plan of treatment is first by means of the sound to ascertain the curve of the flexed organ, and then after bend the applicator (which I have made of soft copper wire) as the sound indicates. Having armed this with cotton wool, firmly wrapped round the distal end to the extent of three inches, and saturated it with iodised phenol, it is passed up the uterine canal to the fundus. By means of the applicator, the uterus is made to revolve till it occupies its normal position, and there it is retained for a few seconds. As a rule the uterine walls will contract firmly on the foreign body and remain rigid and erect. The applicator is then withdrawn, when it will be found that for the time being the uterus does not return to the previous abnormal position, but remains in that to which it had been restored. A tampon soaked with glycerine, of alum and boracic acid is then packed in behind the uterus and allowed to remain for three days, when it is removed and another substituted. As a rule it will be unnecessary to make the application to the endometrium more frequently than once a week.

The object of the tampon is two-fold : first, to retain the uterus in situation, and, secondly, to act as a depleting agent to the hypertrophied tissues. By this method it has frequently been my good fortune completely to overcome the tendency of the uterus to fall back into its retroflexed position, in short to restore it to its normal condition, which it is able to retain without mechanical support. The treatment of such cases will, as a rule, occupy from three to four months, and during this period it is my custom to introduce Hodges' pessary before the menses are expected, and allow it to remain until the flow has ceased, with the view of retaining any advantage that has previously been gained, and afterward the treatment is resumed. In conclusion, I come to speak on the subject which to us gynæcologists is at the present moment engrossing our attention very much. I refer to the treatment of fibroids of the uterus. At the onset I must confess I am neither an apostle of Apostoli nor a disciple of Mr. Lawson Tait. If on the one hand these growths can be got rid of by electricity, applied to the endometrium, or by the more dangerous method of applying the current directly to the tumor, or on

the other by removal of the uterine appendages, by which the blood supply of the ovarian vessels is removed, I would ask, can the end not be accomplished by so restoring the equilibrium of the uterine circulation and power of its muscular structure that the blood supply will only be sufficient to nourish the normal tissue to the disadvantage of the adventitious growth, so that the latter will assume the character of a foreign body, which it undoubtedly is, and the former by its contractile power will either be the means of starving it out of existence, or expelling it from its niches. These may be considered very crude ideas, but facts are stubborn things, and with these remarks I will proceed to defend the position I have taken up. Seven years ago, I was called to attend a case of endometritis which had completely undermined the health of the patient. She had a copious muco-purulent discharge from the uterine canal, and at the catamenia the flow was excessive. On the examination I could detect a small myoma in the anterior wall just beyond the cervix,—but to this I gave very little attention, and proceeded to treat the endometritis which existed in my usual way. The result was so far satisfactory that the patient improved very much in health, but whenever treatment was discontinued she fell back again to her former condition of ill health, till on one occasion on applying to the canal the applicator when withdrawn was minus the cotton wool with which it was loaded, and do what I could I failed to extract the cotton; so I was obliged to console myself with the fact that it was charged with an aseptic substance, and would do little or no harm, though it did not come away for a day or two. Within a few hours of the patient's return home, she was seized with violent uterine pains, and I was sent for to find her suffering very acutely. In a short time, however, the small fibroid before mentioned had shot down to the vagina, and with it the cotton I had left in utero, when all pain ceased. I removed the polypus, and from that time the patient has not suffered from any uterine trouble; but on the contrary has borne two children.

During the past three years I have treated many cases of fibroids by acting on the endometrium, and, through it, upon the uterine walls, and with the most gratifying results, which I must, however, leave to the subject of a future communication to the society.

LOCAL DEPLETION IN PELVIC DISEASE.—While this term is one peculiar to the allopathic school of medicine, it has also been adopted, lately, by many of our pseudo-homœopaths, who more frequently employ it ignorantly than otherwise. Dunglison defines it as “the act of emptying or unloading the vessels, by blood-letting and the different evacuants.” One class of practitioners

use the term in connection with the chemical effect of certain hydragogues, for instance glycerin, upon congested tissue through the tampon; while still another class employ the name for treating a tissue by deep penetration of the scarifier or spear-pointed lancet, which may draw daily, or weekly, from six drachms to an ounce and a half of blood. The last still resort to the idiotic practice of attaching leeches to the cervix. We then have, first, a portion of the profession who believe that depletion means abstracting, by chemical affinity of the drug employed, a certain portion of the blood found within the congested parts, while the second class insist that depletion only means withdrawing blood itself from the tissue by puncturing the parts, creating a slight hemorrhage. Let us see the advantages of both methods. The tampon form of treatment is recognized as a powerful adjuvant, and is, we think, the more preferable. Chronic or recurrent pelvic congestions improve under its use. The neurotic symptoms associated with a puffy, blue, plethoric cervix markedly improve under judicious local depletion, combined with glycerole packs and tamponing. It is equally serviceable and speedy in cervix lacerations with eversion and lip infiltration. Many cases of this type recover perfectly when thus treated, and remain well if the uterus be prevented from sagging, by giving proper support to a torn or relaxed outlet. Except in the latter condition, when associated with lacerations, depletion is not often called for in spare or anæmic patients. The procedure, to be of value, must be thoroughly carried out. We are in the habit, says an eminent gynecologist, of drawing from six drachms to an ounce and a half of blood every five days, or once a week, following the depletion immediately by a glycerole or boracic acid pack, which is often retained until the next depletion. The cervix on both vaginal and uterine surfaces has been depleted, as well as the vault of the vagina. The last does not offer any special advantage over the cervix. Serious difficulties have occasionally arisen from too deep penetration of the scarifier, which may wound an artery of large caliber, and give rise to alarming hemorrhage. Difficulties also arise in the use of the spear-pointed instrument. This often occasions great pain to the patient, obliging the operator to desist, or to make but few punctures. A serious objection to the straight instrument is that depletion can only be practiced with safety and satisfaction upon the prominent and rounded extremity of the cervix.

Certain forms of tenaculums are made like an ordinary tenaculum, but with a blade in place of a hook. This blade is placed at an angle slightly obtuse to the handle, and about the same length as the point on the ordinary rectangular uterine tenaculum. In using it the cervix should be fixed by a tenaculum in

the uterine canal, when the small, short blade of the instrument can be plunged rapidly in a number of places into the vaginal surface of the cervix anteriorly and laterally, and even within the cervical canal. It is sometimes used to open a very small external os. The shortness of the blade, and its being at an angle to the shaft, prevents a deep, dangerous penetration. If the cutting edge be kept sharp, and used rapidly, it occasions, as a rule, but little pain to the patient. This tenaculum is made entirely of metal, $7\frac{1}{2}$ inches in length, tapering gracefully from the handle to the blade, which is $\frac{3}{8}$ of an inch long, $\frac{1}{8}$ of an inch broad at its base, $\frac{1}{8}$ of an inch wide on its back.

In the discussion, Dr. Da Costa thought if from one to four or more ounces of blood were removed, better results would be obtained. A woman who, when placed on the table, was suffering severe pains, and had an angry-looking uterus, would be rapidly relieved and the uterus would pale down. He used a straight bistoury to puncture the neck all over, and inside as well. Even a cut artery was of small matter. The trouble usually was that the bleeding stopped too soon. If he removed the speculum the bleeding almost always stopped, but the speculum was always replaced to make sure that this was stopped.

Dr. William Goodell remarked that in most cases simple exposure of the cervix to the air by the speculum caused it to become pale, although he granted that the effect was caused by the loss of blood. He used to bleed very frequently, and occasionally did so, but not so often as formerly, because he believed the importance of uterine congestion was overrated. While hemorrhage was not usually to be feared, yet one patient had bled so furiously after she reached home that she had to send for a physician to check it. On one occasion, while plunging a Battles spear, he struck a vessel of such size as to throw a stream directly out of the speculum. But ordinarily the difficulty was to secure enough blood. When the punctures bled too much, he touches each one with a pointed stick of lunar caustic, which never failed to stop the hemorrhage.

Dr. Parish had practiced Dr. Kelly's procedure whenever the uterus was congested, whether cervix laceration existed or not, with excellent results. In many cases perfect union of the denuded surfaces resulted, but the pain and distress continued, and dysmenorrhœa increased. When the laceration was not deep, depletion, conjoined with other methods, was substituted for trachelorrhaphy. Cervix depletion gave excellent results in endometritis. Sterility of a decade's standing had been practically cured by it.

Dr. Kelly thought that the loss of an ounce and a half of blood every few days was sufficient. In depleting, he put the

patient on the back, with Goodell's speculum in place, which conducted the blood into a wide-mouthed vessel of graduated capacity.—*Med. Standard.*

WHOOPIING COUGH.—The value of Mobin's treatment of whooping cough by sulphurous acid is receiving strong confirmation from many sources. Dr. Manly expresses the opinion that if it was carried out in every case, at the end of six months the disease would be unknown. The method used by him is as follows: the patient is in the morning put into clean clothes and removed elsewhere. All his clothes and toys, etc., are brought into the bedroom, and sulphur is burnt upon a few live coals in the middle of the room. The fire is allowed to remain in the room for five hours, and then the windows and doors are thrown open. The child sleeps in the room the same evening. About twenty-five grams (a little under an ounce) of sulphur to every cubic metre may be burnt; this is equivalent to rather more than ten grains per cubic foot. The room is fumigated in a like manner during the night; the patient practically living in an atmosphere of diluted sulphurous-acid gas for some days, while in several cases the process is repeated at the end of a week.—*Polyclinic.*

MISCELLANY.

—For topical application for cracked nipples the following has been employed with great success: "As soon as there are any appearances of cracks, or even tenderness of the nipples, a compress, folded in four and steeped in boracic acid solution (three or four per cent.) is applied. Oil silk is placed over the compress to prevent evaporation; over this a layer of cotton wadding, and the whole secured by a bandage."—*Amer. Practitioner.*

—Dr Philip Porter has been seriously ill for several months and has in consequence been unable to give his usual attention to journalistic matter. Under advice of his physician he is now seeking renewed health in the Southern States, and bears with him the hearty good wishes of his many friends.

—**CAUSES OF BREECH PRESENTATIONS.**—**DR. E. S. MANSFIELD,** in *Omaha Clinic.*—We know that very trifling conditions will often be productive of very important changes in life. Permit me here to draw your attention to one of these, of grave consequence to child and mother. I refer to the occurrence of breech presentations. In my practice of eight years in the city of Chicago, in a

part of it where midwives did the most of midwifery, I came across a great number of these presentations, and after practicing in Nebraska for thirteen years, I have met but two or three of them, and have no doubt that you have had the same experience. I have tried to eliminate the conditions which the Chicago and Nebraska mothers are equally subject to, and find but one which could be blamed as a cause of the greater number of breech presentations in the city—the climbing of stairs—a practice under no condition favorable to the well-being of the woman—becomes, in my humble opinion, the prime cause of these presentations.

ERGOT IN OBSTETRICS.—Dr. J. W. Hyde, in *Arch. of Gyn., Obs. and Pæd.*

—First. Ergot, administered prior to delivery, produces a frightful mortality among the infants.

—Second. It is liable to produce rupture of the uterus, as well as of other maternal soft parts.

—Third. It is improper treatment, in lingering labors, with inertia uteri, as the forceps are far safer to both mother and child.

—Fourth. Ergot is a more frequent cause of the retention of the placenta than all other causes.

—Fifth. It adds much needless distress to already exhausted mothers, by the prolonged after-pains.

—Sixth. The retained placenta is frequently the cause of other disasters, the manual or instrumental interference necessary to dislodge it often producing traumatism or sepsis, or both; and from these we may have perimetritis, suppression of the lochia, suppression of the milk, and we may even have puerperal insanity and embolism as indirect sequences. The same argument may apply to the retention of clots.

—Seventh. It is a very potent factor in the production of sub-involution and displacements.

—Eighth. Ergot is never necessary. If there is no more than the usual moderate hæmorrhage which ordinarily accompanies a delivery, the uterus will take care of itself. If there should be a sudden and alarming hæmorrhage, the patient is already suffering from SHOCK, therefore the use of ergot by the stomach would be useless; and if it was not immediately rejected, it would not be absorbed. The hot-water intra-uterine douche is efficient and preferable for controlling the hæmorrhage.

In dangerous cases of post-partum hæmorrhage, the hypodermic injections of ergot may be used, as this would be of value as against the negative results of ergot by the stomach.

—Ninth. Ergot has been condemned and abandoned by many of the largest maternities in Europe and this country.

THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

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SPECIAL NOTICE.—During his recent illness, Dr. Porter was counseled to resign the editorship of this journal, and for the present it has been decided to place the editorial conduct in the hands of the publisher, and communications relative thereto should be addressed to A. L. CHATTERTON, New York.

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MARCH, 1889.

VOL. XI.

SHOULD WOMEN WITH HEART DISEASE MARRY?

BY J. W. DOWLING, M.D.,

Professor of Diseases of the Heart and Lungs, and Clinical Medicine, New
York Hom. Med. College.

From papers which have been recently read before some of the old-school medical societies, and from the discussions which followed, as well as from the writings of those claiming to be authorities on the subject, we would be led to believe that the danger to life, of women suffering from the various forms of organic disease of the heart, during pregnancy, is extreme, and that if these unfortunate ones were enabled to go through to full term without accident, their chances of passing the ordeal of labor with lives spared were less than even.

One writer places the death-rate at 60 per cent., and claims that of the children born alive few develop well, and that of those who live the majority die before reaching their fifth year—and to all of this is added the statement, that miscarriage is far more common among woman suffer-

ing from cardiac disease than among pregnant women free from this complication.

On the strength of these statements, and his evident further researches, it is not surprising that Dr. Sturtevant of Ohio at the last meeting of the American Institute of Homœopathy, should have "solicited attention to an inquiry into the cause of the discrepancy in the estimation of peril to mother and child, with which these complications are held by the two leading schools of medicine." After a brief *résumé* of the subject, he concludes that the mortality to mother and child, and the frequent miscarriages, are due to the indiscriminate and reckless administration of powerful drugs, particularly digitalis and potassa, and shows by quotations from old-school authorities the undoubted action particularly of digitalis, of inducing uterine contractions and of depressing the system generally. Whether this inference be correct or no, certain it is that, so far as my knowledge goes, no such mortality exists in our own school of medicine, and I am even inclined to believe that the reported enormous death-rate, where this complication exists, in the old school is an exaggeration, or that the statistics were taken from lying-in asylums, frequented by women broken down by the effects of intemperance or of syphilis; or that many cases of cardiac disease in pregnant women have remained undiscovered, and consequently results have not been reported,—the dyspnœa, cough, palpitation, and œdema arousing suspicion in grave cases, attended with dilatation without compensating hypertrophy, or with degeneration of the heart walls from atheroma of the coronary arteries complicated by chronic interstitial nephritis, and reminding the attending physician of the necessity of a careful physical examination—and that from such truly alarming cases the unfavorable statistics have been largely taken.

With this excessive reported mortality, it is not surprising that the advice is so generally given by writers on the

subject, to oppose marriage in all women suffering from organic disease of the heart.

Let us ask, Is this advice justifiable in all cases? Even if there be a certain amount of danger attending child bearing, is it not better to take a lighter and more rational view of the case, and, rather than blast the happiness of a young woman or of a young couple, to wait until the emergency arises, and then to meet the danger, and with all the skill of modern science endeavor to avert it. There is another argument in favor of withholding advice so far as matrimony is concerned; few physicians but have been called upon to suffer mortification from tendering advice which has not been followed, perhaps aggravated by the non-fulfillment of the predictions of serious consequences. If the affections of a young woman are involved, with all of the possible alarming results placed before her should she marry, in ninety-nine cases out of a hundred she will decide to take the chances.

A case in point: A young lady, a resident of this city, of great beauty, intelligence, and wealth, after an attack of inflammatory rheumatism complicated by endocarditis, was left with a deformity of the mitral valve, resulting in insufficiency; at the age of 21 she was attended by a skillful bachelor physician who was made aware of the cardiac disease by a personal physical examination; their affections became mutually involved; both realized the probable dangers attending matrimony, or rather its consequences; notwithstanding this, and advice to the contrary, they were married; shortly after their union she became pregnant; nothing unusual occurred throughout her gestation; repeated examinations of the urine were made, but no albumen was found. She went to full term; the labor was a difficult one; finally instrumental aid was decided upon. She had already been placed under the influence of chloroform, and I am informed by her husband was fully under its influence for two hours, when she was delivered of a

dead child. The cervix and perineum were badly lacerated, but she recovered nicely; later she was operated upon for both of these lacerations, on this occasion ether being the anæsthetic used; she made a perfect recovery. Shortly after, she again became pregnant; throughout her entire pregnancy everything, as before, was perfectly normal; at full term she was delivered of twins. The labor was an easy one, there were no lacerations, and she recovered nicely; the children are living and well. One year ago I made a careful examination of her heart. There was a loud regurgitant mitral murmur, with eccentric hypertrophy of the right ventricle, and slight enlargement of the left. Compensation was perfect, and barring the ordinary shortness of breath on exertion, always attending mitral lesions, she was in perfect health; her color was good, and from her appearance no one would suspect a grave cardiac lesion. To-day, for the purpose of this article, I sent to inquire as to her condition, and was informed that she was, and had been since her confinement, perfectly well.

The difficult first labor was in no respects owing to the cardiac lesion, but to the enormous size of the head of the child, and the rigidity of the os. The accoucheur, who was a man of long experience, stated that the head was one of the largest he had ever delivered; the presentation was normal.

It will be noted that chloroform was the anæsthetic used in the first labor, and notwithstanding the reputed depressing action of that agent upon the heart, she was kept fully under its influence for a period of two hours, with no injurious results following. In support of Dr. Sturtevant's theory, I would add, the patient had always been under homœopathic treatment.

CASE II.—Twenty-five years ago I attended Miss C., age 15, during an attack of inflammatory rheumatism complicated by endocarditis; after an illness of two months she recovered, but was left with a chronic valvulitis involving the mitral valve; there was dilatation of the right side of the

heart, with slight dilatation of the left ; for a long time she was quite short of breath on exertion, was pallid, and had slight œdema of the feet and ankles ; finally the pallor disappeared, the feet and ankles became normal, and the dyspnoea was not noticeable except on quite violent effort ; at 18 she entered society and for four years participated in the usual excitement of city life, attending balls, parties, etc., without inconvenience ; at 22 she married, and, at intervals of two or three years gave birth to five children. Of these, four are now living, one having died of diphtheria at the age of five years ; the eldest, a young lady of 18, is now under my care for chlorosis ; the children have all enjoyed the average health of a perfectly sound family, and with the exception of the eldest daughter the four living are now perfectly well. Through her entire married life the mother has enjoyed excellent health, every labor has been perfectly normal, and she has had no miscarriages. Three years ago certain symptoms led me to make a vaginal examination, which resulted in the discovery of a neoplasm projecting from the cervix ; an operation was advised, and the tumor was removed by Prof. L. L. Danforth of the New York College. Ether was the anæsthetic used, no special inconvenience was felt from its use, and she made a speedy recovery. Prior to the operation I made a careful examination of her heart, the first in several years ; the signs were precisely the same as in Case I. : General hypertrophy, decidedly more marked on the right side, with a loud mitral regurgitant murmur, and diminished vital capacity. The patient is now in the enjoyment—so far as she knows—of perfect health, although twenty-five years have elapsed since the endocarditis which caused the valvular lesion. She has always been under homœopathic treatment.

CASE III.—Mrs. M. aged 35, had inflammatory rheumatism at 18 ; finally recovered, married, and has since had three children ; the eldest is now 12, and all are perfectly healthy. The mother has enjoyed good health till two years

ago, when from the effects of a cold she had a protracted cough and shortness of breath, with swelling of the feet and ankles. I was consulted and found, on examination, diminished vital capacity, great increase in the area of heart dullness to the right, and a loud presystolic mitral murmur, with a small quantity of albumen in the urine, no casts. Under treatment, in the course of a few weeks she regained her former good health, and has remained well ever since. On inquiry I found that she had been more or less short of breath on exertion since her recovery from the attack of inflammatory rheumatism. She had had but one attack, and although the family were not informed of a heart complication at the time, and she had not been aware of the permanent heart lesion, I am satisfied that it had existed undiscovered through all these years; for there had been no illness but the one, which could give rise to such a complication, and at the time of my examination there were no evidences of acute endocarditis, and the lesion was evidently an old one.

CASE IV.—About four years ago I was requested to visit, in consultation with the late Dr. Pratt of this city, a lady about 37 years of age, suffering from great shortness of breath, with orthopnoea, and dropsy of the feet and ankles. The history of the case was as follows: when a child had suffered from inflammatory rheumatism; recovered after a siege of some ten weeks; was feeble for a long period, but was finally restored to perfect health; married at 25, had had four children, the last but three months prior to my visit. She had enjoyed good health to the time of her present illness, and had never been short of breath on exertion.* Examination showed great enlargement of the left ventricle, with an aortic systolic murmur, pulmonary en-

* In aortic stenosis where there is sufficient compensating hypertrophy of the walls of the left ventricle the patient is not short of breath on exertion; with mitral lesions there is always diminished chest capacity, and consequent dyspnoea on exertion.

gorgement, with œdema at the base of each lung, bloody serous expectoration and albuminuria, granular and hyaline casts in the the urine. She had passed through all of her confinements without trouble; had never been aware of the existence of any heart trouble, although she had always been exceedingly sensitive to cold and had at times been unusually pallid. Shortly after the birth of her last child had noticed a lack of strength, loss of appetite, shortness of breath on exertion, and diminished quantity of urine, with indigestion, belching of wind and constipation, with gas in the intestinal canal. The lesion was, of course, stenosis of the aortic orifice of long standing, with, at the time, dilatation of the hypertrophied left ventricle, and general weakness of the heart muscle. The heart failure was undoubtedly in some way connected with her recent confinement, although it did not show itself at the time; as a complicating cause, I thought of malarial cachexia, for she lived in a rather miasmatic section in the upper part of the city. Under treatment consisting of absolute rest and an exclusively milk and farinaceous diet, with *Arsenicum* and *Convallaria* as remedies, she finally to a certain extent recovered, although she has not returned to her normal condition of health.

CASE V.—Mrs. R. H. M., age 63; rheumatism as a child, fair health through life; had without unusual trouble given birth to two living children, both healthy—one had died from some acute disorder at the age of 30, the other still living, and about 40 years of age.

Heart lesions—aortic stenosis and insufficiency of the mitral valve, with general hypertrophy of the walls of the heart. This lady lived two years from the time of my first visit, but was never well, and finally died from the effects of gradual heart failure. In this case, the question would naturally arise, was not the heart disease of comparatively recent date, and owing to the extension of an atheromatous process from the walls of the aorta to the aortic valve, and

to the coronary arteries? I should unhesitatingly answer in the negative, for there were none of the usual signs of general atheroma, and she had been conscious of the existence of heart disease for many years.

I have detailed these cases which have come under my own observation, to show that the dangers attending child-bearing in women suffering from organic diseases of the heart, under proper surroundings, are not so great as has been supposed. They are not given to prove the advantages of homœopathic treatment in the management of these diseases—for Cases IV. and V. were under old-school treatment at the times of their pregnancies and deliveries.

Perhaps the question will be asked, where are the unfavorable cases which have come under my treatment and observation? In reply I would say that although I have known of many who have died of heart disease, acute and chronic, I can remember no deaths, in a practice of thirty-two years, of women suffering from valvular disease of the heart, as a result of pregnancy or its immediate consequences. I could have added to this list the case of one lady married, but who has never been pregnant, whom I have had under my care for nearly 30 years, who, as the result of an attack of rheumatism, for twenty out of the thirty has been crippled to a certain extent by a constriction of the mitral orifice, but who notwithstanding this has enjoyed a comparatively healthful life, but with occasional grave reminders of danger, and to-day she is in as good health as at any time since her attack of rheumatism. Throwing this experience out of the question, let us ask, why should women suffering from valvular disease of the heart not marry? The question applies only to those where valvular deformity is the result of acute endocarditis, and whose hearts have become sufficiently hypertrophied to largely compensate for the obstruction to the blood current caused by the deformity, whether it be constriction of the orifice, or insufficiency of the valve; for no woman with

valvular disease uncompensated, or with dilatation or degeneration of the heart walls, would be in a condition to entertain for a moment the thought of marriage or the immediate effects of the first few days of married life.

In reply to this question, after years of careful study of organic and functional disease of the heart, real and imaginary, I unhesitatingly answer, I know of no valid reason. In addition to those narrated above, which have been cited on account of their special bearing on the subject under consideration, I can call to mind many cases of heart disease, in women and in men, which have remained undiscovered for years—during which time these people have pursued their ordinary vocations, enjoying as good health as the average woman or man, free from suspicion of disease of any of the vital organs; and cases, too, when the condition has been correctly diagnosed, and unfavorable prognoses given, the patients suffering for a time from fright, at the thought of the gravity of their ailments, and the possibility of sudden death, but gradually calming down and losing their fears, when the experiences of every-day life have taught them that the danger was not so great as they had supposed.

I have seen cases too, and these by far the most distressing, so far as the comfort of patients, friends, and physicians was concerned, when large portions of patients' lives have been rendered miserable by careless and mistaken diagnoses on the part of physicians. One case I have in mind at this moment. I was called in counsel by a physician in this city to see a case of acute endocarditis in a child. After finishing my examination, I was requested to examine the mother, a healthy looking woman of about forty-five, with two grown daughters besides the child who was ill. I found her color good, her chest expansion and vital capacity normal, the area of cardiac dullness normal, the heart sounds pure at all of the orifices, and both arterial sounds pure in the neck. I unhesitatingly pronounced the heart perfectly sound. To my astonishment I was informed that for twenty

years the lady and her husband had been laboring under the impression that she was suffering from organic disease of the heart, which should incapacitate her for work, and which rendered her liable to sudden death from any great exertion or sudden emotion, and that the opinion had been given by an old-school physician who had formerly held the position of physician to the port of New York. In this time she had given birth to, and reared, three children, but had been most carefully watched, and never allowed to exert herself in the least. It seemed as if my positive statement as to her soundness was like a bombshell thrown into that household. The physician then in attendance had never been called upon to examine her.

The time was when a heart murmur was considered positive evidence of heart disease, and when every case of heart disease was supposed to incapacitate the patient for the most simple duties of life, and that time so recent that even the younger members of the profession can recall it. The time was when hypertrophy of the heart, or any part of it, was looked upon as a disease process, instead of an effort on the part of nature to overcome obstructions to the blood current, which it most certainly is; and even text-books of recent date treat of hypertrophy and dilatation under the one heading. Fortunately it has now been demonstrated, time and again, that nature is competent and, if the nutrition of the patient be good, does, by the development of new muscular fibers, so enlarge and strengthen that portion of the heart back of the obstructed orifice, as to enable it to largely overcome the impediment to the blood current, and if the habits and life of the patient be good this compensation continues often to extreme old age.

With this demonstrated fact before us, it stands to reason that a purely physiological process should not be attended with the dangers which have been, in my judgment, so unwisely attributed to it.

If the discrepancy referred to by Dr. Sturtevant, in the

peril to mother and child when there are cardiac complications resulting from acute endocarditis, so far as the two leading schools of medicine are concerned, really exists—and my personal experience compared with that of the old school, of which I have read, would convince me that it does,—I believe the explanation he gives is the valid one. Digitalis—potassa—dosing—constant dosing, to overcome an incurable deformity, of the existence of which the doser could not be aware, but for the murmur, or the evidences of heart enlargement which have been revealed by physical examination. Every drug must have its toxic effects if its use is continued in doses sufficient to obtain its physiological action; and probably to this long-continued poisonous drug action may be attributed the great mortality to mother and child under old-school régime when cardiac complications exist.

Before closing this article, I wish again to call attention to the fact that in each of the cases to which reference has been made, the cardiac difficulty has been the result of acute endocarditis, complicating inflammatory rheumatism, and the valvular deformity has in each case been largely compensated by hypertrophy of the heart walls; and to these cases, and these only, would I withhold objections to matrimony, or any course in life known to endanger the weak heart, such as a rough sea-voyage with its attending "sea-sickness," ascending to a very high altitude, or indulgence in extra mental or physical efforts. There is a form of heart-disease which, but in exceptional cases, makes its appearance after the period of child-bearing has passed. I refer to valvular disease, and weakness of the heart-walls, later with actual degeneration resulting from artero-capillary fibrosis, with atheroma of the aorta, extending to the segments of the aortic valve, and involving the coronary arteries. In these cases, which can be diagnosed even in their early stages, the intrinsic ganglia of the heart are nearly always involved, and an extra effort or even severe

mental excitement is liable, by the pressure resulting from the overloading of the heart cavities, to paralyze these ganglia and stop the action of the heart. Should pregnancy occur in such a case, the chances of safe delivery at full term would be exceedingly small. As was before stated, except when there is a syphilitic complication, or where the subject has led a grossly intemperate life, it rarely appears till long after the child-bearing period is passed. Acute endocarditis] or pericarditis, with or without myocarditis, may complicate pregnancy, and if the patient recover, the dilatation remaining, which had not as yet been compensated by hypertrophy, would undoubtedly so weaken the heart as to seriously endanger the life of the patient at the time of delivery; but these cases are rare, and are hardly to be thought of in a general consideration of the subject of "pregnancy complicated by organic disease of the heart." Should such a grave condition arise, an early resort to instrumental delivery under ether, which is not contraindicated in the case of weak or diseased heart, would be advisable.

SENILE OR ADHESIVE VAGINITIS.

BY JAMES C. WOOD, M.D., ANN ARBOR.

Dr. Alfred McClintock, at the June 11, 1870,* meeting of the Dublin Obstetrical Society, presented a paper entitled "Senile Contraction of the Vagina," in which he describes certain pathological changes corresponding to those resulting from the type of inflammation designated by the title of this article.

Doctor McClintock first refers to the frequency of contractions, contortions, and occlusions of the vagina resulting from cicatrices and adhesions. These sequelæ of inflammation and sloughing of the vagina are familiar to all practical

* Dublin *Quarterly Review*, vol. 50, p. 17.

gynæcologists and obstetricians, as are also those minor forms of contraction resulting from projecting transverse folds, and presenting to the finger a sharp crescentic edge like that shown in Figure 1.*

In the paper referred to, the writer next reminds the reader of the well-known fact that the upper part of the vagina is, normally, both capacious and distensible. In both married women and in virgins the finger can be passed freely into all of the fornices, between the cervix and the vaginal walls. In the peculiar form of vaginitis under consideration the conditions are quite altered. "There is," says McClintock, "a progressive diminution of the calibre of the vagina—not throughout

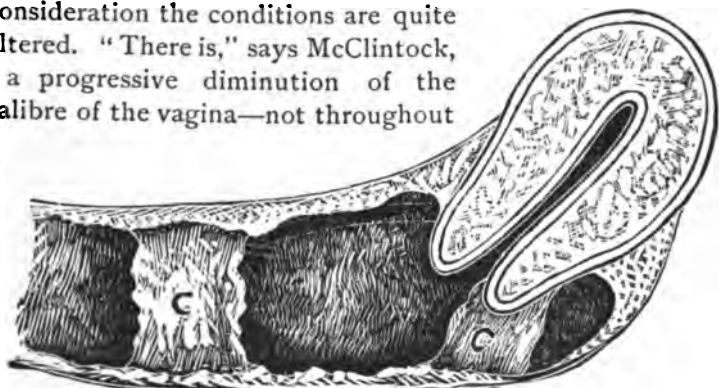


Fig. 1.—Vaginal Section; c, c, Cicatricial Bands.

its entire extent—but commencing at its summit and slowly advancing downward. When the contraction has reached the level of the os tincæ, the introduction of the finger into the vaginal cul-de-sac around the cervix becomes quite impossible, this part (cervix) being so closely embraced by the broad ribbon-like structure. With

* The patient from whom this cut was taken presented herself at the university clinic with complete laceration of the perineum, the rent in the recto-vaginal septum extending to the cicatricial projection. Before the laceration could be repaired I found it necessary to overcome the contractions by cutting and dilating them. My object in presenting this cut is to show, by contrast, the difference between this not unusual form of contraction and cicatrization and the rarer types seen in Figures 2 and 3, which McClintock, and two or three other writers, have described under different names.

the persistent increase of the constriction the os and cervix become quite encapsulated, and beyond the reach of touch or sight. The foramen through the stricture, in two of my cases, was so small as barely to admit a probe, and might very readily have been mistaken for the os uteri itself. How much lower down this process of contraction may extend, I can not at present say, the cases which have longest been under my observation being married women, and I should imagine that sexual intercourse would tend to hinder or retard the progress of the contraction downward."

Simpson,* in a chapter devoted to "Closure and Contraction of the Vagina as a Result of Inflammation, and Independently of Pregnancy," introduces his subject by describing, first, those forms of vaginal inflammation occurring oftener in children, and which result in contraction and closure of the canal at its lowest point. This form of inflammation is also frequently met with and is easily recognized. I desire, nevertheless, to quote in detail from Simpson:† "You may meet likewise among adults with cases of a kind of adhesive or obliterative vaginitis of an analogous type. But the disease in adults differs from the disease in infants in one or two important respects. In infants the inflammatory closure is usually limited to the very orifice of the vagina, and produces complete occlusion of the canal. In adults it generally commences at the upper part of the vagina, and spreads gradually downward, and seldom causes complete closure. In infants there is commonly cohesion merely of the opposed sides of the orifice of the vagina, without any tendency to circular contraction in the calibre or circumference of the orifice. In adults, on the contrary a state of inflammatory cohesion and obliteration is almost always attended with a simultaneous tendency to circumferential contraction of the canal

* "Diseases of Women," vol. iii. p. 269.

† Ibid. p. 260.

at the site of the disease, so that when it is limited, as it often is, to the top of the vagina, the os uteri is felt drawn up, as it were, to the apex of a narrow, conical, or funnel-shaped cavity. . . . There is evidently a tendency in some rare cases to the occurrence of obliterative inflammation of the uterine canal itself ; for in the instances I refer to, you may open up the canal repeatedly with the uterine sound, and yet they will occasionally come back to you with perfect amenorrhœa, and when you pass the sound along the canal you will have the sensation imparted to you of the instrument separating the adherent surfaces, just as you can feel the adhesions of the vagina separating under the pressure of the finger."

McClintock's paper was published in 1870. Simpson's work was not issued until 1872, but the editor, A. R. Simpson, states in his preface, that "the greater

number of lectures contained in this volume appeared in the *Medical Times and Gazette* during the years 1859-1861." Whether or not this particular lecture was published at that time I do not know. At any rate McClintock makes no reference to it in his paper. I have thus quoted somewhat at length from these two writers, because they are the

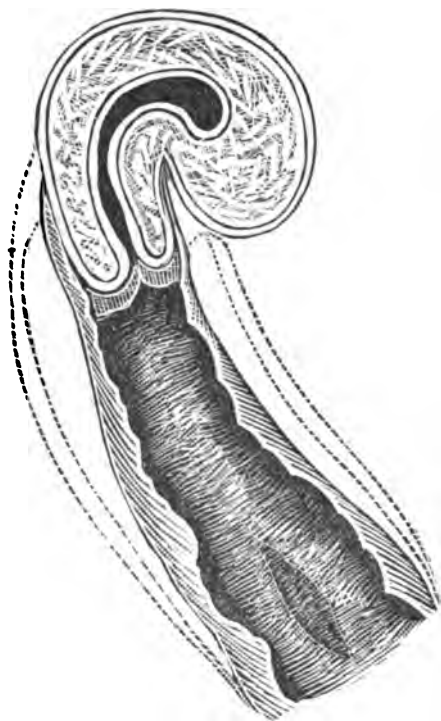


Fig. 2.—Contracted Vagina. Dotted Line showing Normal Outline of Vagina.

only ones in the whole range of literature which I have traversed who give anything like a comprehensive description of the peculiar and, it can safely be said, rare condition which forms the subject of this paper.

Prof. A. J. C. Skene presented in 1877 a most admirable essay to the American Gynæcological Society, on "Cicatrices of the Cervix Uteri and Vagina." * In it the author deals especially with those forms of contraction occurring below the fornix vaginæ and resulting usually from parturition. Three clinical cases are recorded by Skene, one a nullipara who had during childhood what was supposed to be a "typho-malarial" fever, followed by pelvic inflammation and abscesses—a point worth noting in connection with the cases whose records I shall present. In this essay no mention is made of McClintock's and Simpson's articles; nor does Skene in his latest work † have anything to say of "adhesive vaginitis."

Bedford, ‡ in a series of clinical cases, describes adhesions of the upper portion of the vagina caused by the unskillful use of instruments, but an analysis of these cases shows them to be not unique in their pathology.

May, § evidently deriving his information from Fritsch, dismisses the whole subject in six lines.

Tilt || refers to "vaginal contraction" as a result either of traumatism or chemical irritants, but says nothing more.

Sims ¶ treats of certain unnatural conditions of the vaginal vault, either congenital or acquired, giving rise to sterility, but he conveys to the reader no definite idea of the peculiar vaginal deformity under consideration.

Fritsch, ** on the other hand, evidently looks upon the

* Vide Transactions, vol. i. p. 91.

† Diseases of Women, 1889.

‡ Clinical Lectures on Diseases of Women and Children, pp. 347 and 379.

§ Manual of Diseases of Women, p. 79.

|| A Handbook of Uterine Therapeutics, p. 241.

¶ Clinical Notes on Uterine Surgery, p. 342.

** Diseases of Women, pp. 96 and 98.

lesion as a pathological entity, giving a brief but very good description of it.

Byford's * description of vaginal cicatrices is confined to those varieties where there is a "frænum-like projection in the vaginal walls," such as is depicted in Figure 1.

Hart and Barbour † say: "The cicatricial contraction of the vagina observed after the menopause is due to senile vaginitis. The epithelium is shed in patches, and the raw surfaces thus produced adhere together (Hildebrandt).

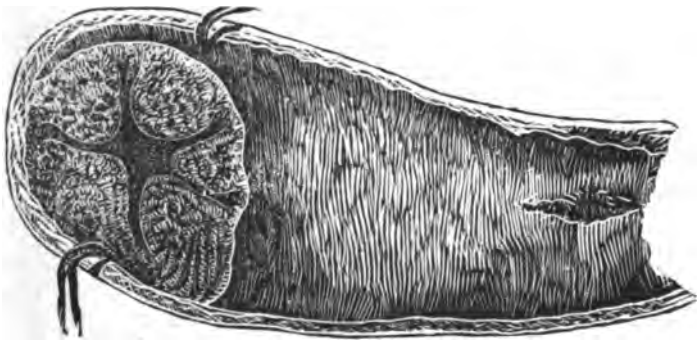


Fig. 3.—The Right and Anterior Fornices Obliterated. The Left Free.

This process is similar to that which produces occlusion of the cervical canal after the menopause."

Southwick, ‡ in his scheme of the several varieties of vaginitis, briefly refers to the senile or adhesive, asserting that "there may be no subjective symptoms whatever."

Breisky § has a very interesting chapter upon "Acquired Atresias and Stenoses," and refers to Simpson's article. He offers no observations of his own bearing upon senile vaginitis.

Cowperthwaite || gives in substance the brief reference to

* The Practice of Medicine and Surgery, Applied to the Diseases and Accidents incident to Women, 2d Edition.

† Manual of Gynæcology, p. 495.

‡ Practical Manual of Gynæcology, p. 115.

§ Diseases of the Vagina, p. 264.

|| A Text-Book of Gynæcology, p. 98.

the condition made by Hart and Barbour, quoting indirectly Hildebrandt's article.

The foregoing literature is the sum total bearing upon the subject which I have been able to discover. For fear of appearing pedantic I will refrain from naming the works ransacked in collecting my data, asserting simply that my researches have not been confined to gynæcological and obstetrical works alone, but have extended to many miscellaneous volumes, society transactions, etc., etc. I have not, however, had access to the article of Hildebrandt, quoted by Hart and Barbour. With the evident dearth of literature treating of "senile or adhesive vaginitis," so called, I venture to record the following cases, the only ones of the kind ever passing under my observation.

CASE I.—A maiden lady, fifty-two years of age. Never has been strong. Commenced to menstruate at thirteen, but was very irregular until sixteen, for which irregularity she frequently took "tansy tea." Until the age of twenty she had frequent attacks of epistaxis, and has occasionally bled from the nose since that time. During her girlhood hysteria was a frequent symptom, particularly before or during the menstrual period; the hysterical explosions were not infrequently followed by decided choreic manifestations, implicating the head, face, and upper extremities. Her menses were fairly regular until the age of thirty-five, at which time she had an attack of what her physician called "typho-malarial fever." Her menses were always more or less scanty, and were associated with a good deal of pain. She ceased menstruating two years ago. Her attending physician during the attack of fever was a "Thomsonian." He administered a powerful lobelia enema which excited the most aggravated retching and vomiting, the patient declaring that she vomited some of the injection. At any rate the prostration following this heroic treatment was both profound and alarming, and she got up from a lingering illness with much pelvic distress.

From that time on there has been an aching, pressing, bearing-down sensation in the pelvis, with dysuria, hemorrhoids and prolapsus of the bowels; menstruation being much more painful, irregular, and scanty, with pain in the region of the ovaries and the uterus, and continuing for a week before and a week after the flow. Indigestion from girlhood has troubled her much, there being times, lasting for days or weeks, when the stomach would immediately eject everything. These attacks of vomiting have recurred at variable intervals up to the present time. The food is ejected soon after eating, undigested, and with but little retching. There is at all times a great feeling of satiety after a few mouthfuls have been swallowed. The patient is very nervous, suffering much with occipital headache, flushes of heat, and insomnia, the latter symptom being aggravated by the menace and worry incident to the care of a large estate. Upon making a local examination I found the condition represented in Figure 2. As the finger passed into the vagina there was no perceptible induration to the touch such as is found in constrictions following inflammation with decided cellular infiltration, or sloughing (Figure 1). There was, however, a decided narrowing of the calibre of the vagina, this narrowing being much more marked at the *os tincæ* than below, so that the canal was funnel-shaped. The fornix *vaginæ* was entirely obliterated, and the cervix could not be found. Owing to the necessarily unsatisfactory bimanual I at first thought that the uterus was absent. Upon introducing a small virgin speculum (Nott's) the entire surface of the vagina was seen to be intensely red and congested. A fair idea of the degree of contraction present at the cervix can be had when it is stated that the blades of the speculum could not be separated more than half an inch. There was a small opening corresponding to the external os, but the cervical canal proper was entirely obliterated. Subsequent treatment reduced the tenderness and inflammation so that I

have succeeded in opening the canal, hoping thereby to relieve the tenesmus and bearing-down sensation. The parts have, under a course of treatment to be suggested later, improved greatly, and the small infantile cervix has been freed from its encapsulation. I should have added that the uterine body is unnaturally small and ante-flexed.

CASE II.—Mrs. C., æt. 52, and the mother of ten children. This patient presented herself at the clinic of Prof. McLachlan, on February 8, 1889. Her father died of phthisis and her mother of cancer. She has three sisters and four brothers, all living. She also has dyspeptic trouble dating back to early childhood, and to obtain relief from which she presented herself at the clinic. There is a history of typhoid fever in early life, though the stomach trouble existed before the onset of the fever. Her indigestion frequently gives rise to vomiting, and there is, and has been for years, a persistent acidity of the stomach with water-brash. There is much flatulence with faintness, and an all-gone sensation at the pit of the stomach. Menstruation ceased three years ago. She has suffered much with dysmenorrhœa, and has had for years much pelvic distress. I was requested to make a local examination, and found what is very nicely depicted in Figure 3. The upper and right fornices were not obliterated, though not as deep as normal. The lower and left were, on the contrary, entirely effaced by the gluing together of the opposing mucous surfaces. The os tinæ was somewhat dilated, and the cervix had suffered a stellate laceration. The vagina was much narrower than normal, though not as small as in Case I. I could not get a good view of the parts with the speculum, but there was much redness and congestion. The patient returned to her home in the interior of the State, and it is not likely that another opportunity for an examination will present itself.

CASE III.—I regret that I can not furnish full notes of

this case. The patient, a woman some 55 years of age, I believe, was sent to me for examination by Doctor Mary E. Havens, of St. Johns, Michigan. Desiring myself to leave town on an afternoon train, I failed, in my haste, to preserve a written record, as I have also failed in obtaining one since the examination. The patient had had a number of children, and there was much mental and nervous trouble, symptoms of insanity causing her friends much anxiety at times. She came to me with an attendant. There was a history of "inflammation of the bowels," which was probably a cellulitis. There was also leucorrhœa, and the patient complained much of stinging, burning pains in the region of the uterus and the ovaries. An examination revealed a vagina in shape not unlike that shown in Figure 2, with an evident bi-lateral laceration of the cervix. Her physician informed me, some twelve months after my examination, that the local condition had quite disappeared under treatment, and that the patient had greatly improved both mentally and physically.

DIAGNOSIS AND PROGNOSIS.—It is not probable that the lesion is a common one, yet it is strange if most practitioners of any great experience in a gynæcological way have not met with this peculiar senile inflammation and contraction of the vagina, and there may be some difficulty in differentiating it from more serious organic disease of the parts. Indeed, such an error is recorded by Byford. The history of the case, the duration of pelvic symptoms, and the local condition described, should be carefully noted in forming a diagnosis. By carefully observing the peculiar funnel shape of the vagina, the obliteration of the fornix vaginæ, and the absence of involvement of the surrounding tissues, the element of malignancy can be eliminated. There are no features of the lesion suggesting an unfavorable prognosis so far as life is concerned; it may, nevertheless, prove a most obstinate one to treat.

ETIOLOGY AND PATHOLOGY.—In 1870 McClintock wrote:

"Although years have elapsed since I recognized this state of the vagina as a distinct lesion, I can give but a very imperfect account of it. I know nothing of its etiology, nor have I had an opportunity of making an anatomical examination of the parts affected, so that I am equally ignorant of its pathology."

In the light of our present knowledge even, we can speak positively concerning neither the etiology nor the pathology. It is worthy of note, however, that in two of my own cases, and in one case recorded by Skene, serious pelvic symptoms dated from an attack of continued fever. There is an abundance of corroborative testimony showing that any low fever may cause alarming vaginitis with cicatricial contractions lower down in the canal. White and Nealton have traced such contractions to cholera; Scanzoni, Hening, and Richter to acute exanthemata; Martin, L. Mayer, and Böhm to typhus. The history of a low or continued fever of any kind should not, therefore, be lost sight of in looking for etiological factors, though a larger series of cases than the one presented will be required to determine this point, and the cause will, in many cases, remain obscure. If in the records presented by myself the disease was a sequel of the fever, the term senile vaginitis is clearly a misnomer. On the other hand, it is hard to explain why in advanced age the fornix vaginæ should take on inflammatory action when all forms of irritation are lacking. Fritsch* observes that cervical catarrh has complicated every case of *vaginitis adhæsiva* seen by him. It is well known, too, that the layer of pavement epithelium becomes gradually thinner as age progresses, thus facilitating an extension of the catarrh from the cervix to the vagina.

The inflammation may be universal or circumscribed, granulating surfaces forming in the vaginal vault which adhere to each other. In this way "the vaginal portion

* *Op. cit.*

may partially adhere to the fornix, so that isolated cords can be felt; or totally, so that the vaginal portion can not be felt at all." (Fritsch.) Hildebrandt * observes that very similar adhesions may occasionally result from ulcerative vaginitis, and where they are firm it is probable that a more destructive process than mere abrasion has existed. Again, it would be hardly possible to have the degree of contraction shown in Figure 2 without secondary cellular infiltration (Ziegler) into the connective tissue of the mucosa, and often, also, of the sub-mucosa. Any other hypothesis would hardly explain the conditions present.

TREATMENT.—There is but little said in the limited literature unearthed concerning the management of adhesive vaginitis, and my narrow experience with the disease will warrant me in doing nothing more than suggesting certain general indications. These are:

1. If the morbid process has given rise to no distress or inconvenience, let it alone.
2. If there is cervical occlusion with uterine tenesmus and general pelvic distress, the stenosis should be overcome.
3. Subdue the existing inflammation and promote absorption of cellular infiltration—(a) by the hot douche; (b) by the medicated cotton-wool tampon.
4. Separate adhesions with the finger, knife, or scissors, when the cicatrices interfere with the functions of the bladder or the bowels, or when dyspareunia becomes a prominent symptom.
5. Control reflex and constitutional symptoms with the indicated remedy.

* Briesky.

UTERINE FLEXIONS.

BY WILLIAM HARVEY KING, M.D., NEW YORK.

Among the various diseases of the female generative organs, flexions hold a very important place, and, as the various methods of treatment are not satisfactory, makes its treatment with electricity more important. Certain cases of flexion are associated with cellulitis, and, if this is of an acute character, it should be subdued to such an extent as to allow a sound or electrode to be introduced into the uterine cavity before the regular treatment of the flexion is begun. As the treatment of cellulitis has already been given,* we will pass over it and confine ourselves to the treatment of flexion alone.

We should rely principally on the galvano-faradic current (the positive pole of the galvanic battery is attached to the negative pole of a secondary faradic coil). In order to *successfully* treat cases in the department of gynæcology it is essential that the operator should have at least two secondary coils; one should be composed of a very long and thin wire, and the other of a short and thick wire. The former gives a current of tension or quality which is soothing in its effect, and is very efficacious in relieving both pain and congestion. The latter gives a current of quantity and has a very irritating effect on parts that are sensitive or congested, but it has greater power to cause muscular contraction and improving the nutrition of the parts. In buying a battery, it is best to buy one of the Du Bois-Reymond type, with two or three secondary coils that are composed of wire ranging from No. 22 to No. 38.

In treating uterine flexions, one large electrode should be placed over the abdomen. This may be a clay electrode, or any other large abdominal electrode, but it should be one through which 150 milliamperes can be passed without

* *North Am. Jour. of Homœopathy*, Aug. 1888.

burning the integument. The internal electrode should be flexible and so bent that it can be passed into the uterine cavity. It will often happen that it can not be made to pass the flexion. In this case, it should be pressed against the obstruction during the treatment, and, if the instrument has been made to the shape of the uterus, after a few treatments it will pass through. If there is sensitiveness or signs of congestion, the fine secondary coil should be used: but if not, the coarse coil should be employed, as its beneficial effect is much greater than the fine coil. The uterine electrode should be attached to the reaphore leading to the negative pole of the galvanic battery. As strong a current as can be borne should be given. The best way to give a treatment is to turn on the galvanic current before the faradic battery is started. In applying the galvanic current, give just a little less than the strongest current that can be borne by the patient—for instance if the patient could bear 200 milliamperes, only turn on 150. After the secondary coil has been drawn entirely off of the primary, start the faradic battery, and then gradually shove the secondary over the primary coil until you get all the irritation that can be borne. This treatment may be continued for from ten to twelve minutes, and repeated twice a week.

Just how and in what manner this treatment cures the flexion I am unable to say, as our knowledge regarding its cause and pathology is too incomplete for us to come to any definite conclusion regarding its cure. The most generally accepted theory is that defective nutrition in the walls of the uterus is the cause of flexion, and when we consider the cataclytic effect of the galvanic current and its power to absorb adhesions and inflammatory deposits of all kinds, thus removing all obstacles to the returning of the uterus to its normal position, and then consider the nutritive effect of the faradic current on involuntary muscles, we can

easily form at least a very rational theory regarding the mode of cure.

The electrical treatment may be given in conjunction with any of the other approved methods of treating flexion; but, speaking entirely from experience, I believe that if the treatment given above be carefully followed out, 90 per cent. of the cases that come under the physician's care will be cured.

I report the following case :

Mrs. K., German, æt. 26 years, came to me in April, 1886. She had been married four years, had never been pregnant, and it was for this sterility that she consulted me. History revealed that she had had a rather severe pelvic inflammation about six years previous. Examination showed an anteflexion just above the juncture of the cervix with the body of the uterus, the surrounding cellular tissue hard and quite sensitive to the touch, and the uterus firmly fixed by adhesions. Treatments were given twice a week (as directed in previous part of this article). The uterine electrode passed the flexion for the first time during the fifth treatment. On account of the sensitiveness, the fine coil was used during the first three treatments and the medium coil during the next two; the coarse coil being used for the first time at the sixth treatment. At that time I did not employ the milliamperere meter, but used twelve Le Clanche cells, which probably gave from 50 to 75 milliamperes. No bad results followed any of these treatments. For the previous six years she had suffered great pain during the whole menstrual epoch, which was about three days; but on May 15, after the sixth treatment, the flow came on accompanied by some pain, which however disappeared after a few hours, leaving the rest of the menstrual period free from pain. From the time she first consulted me until July, seventeen treatments were given. At this time the sensitiveness had entirely disappeared, the cellular tissue materially softened, the uterus

was perfectly movable, and the last menstrual flow entirely free from pain. I did not see her again until my return to the city in September, when I found her pregnant. She is now the mother of two children and enjoying good health.

CORPOREAL ENDOMETRITIS.

BY W. H. LOUGEE, M.D., LAWRENCE MASS.

It is with doubts and fears that I approach a subject that is fraught with so much of mystery, and surrounded by so many doubts and disagreements in regard to its real structure, normal functions, and pathological conditions as the endometrium and its diseases.

The first thing to know is, of what is the endometrium composed, what its histology, and what its normal functions? Then we can better understand both when perverted.

The uterus is composed of three coats, an external serous coat, a middle or muscular layer, an internal mucous or some other kind of a coat covered with epithelium.

There seems to be much difference of opinion by distinguished histologists and gynæcologists as to whether the endometrium is composed of mucous membrane or of adenoid tissue.

Dr. Johnson, an American physician who has been experimenting for some time with Tait of England, has demonstrated very conclusively that the cavity of the uterus is not lined by a mucous membrane covered by epithelium, but by an adenoid tissue covered by epithelium.

In order to have the cavity of the uterus in a healthy state the epithelium to a certain extent must be thrown off, in order for the ovum to come in contact with the adenoid tissue, which is essential for pregnancy to take place.

The influence of disease of the endometrium upon the matured functions of the tissue is very important to know, but very difficult to find out so long as so little is known of the diseases that affect the deeper tissues below the adenoid.

There seems to be no question but that the uterus is more prone to disease than any other organ in the body, which fact renders it more than probable that Dr. Johnson is right in considering the endometrium adenoid in its histological make-up.

Such being the case, let us for a moment see what cytogenetic tissue is capable of producing when properly stimulated, so that in endometritis we may better know what forms of disease to expect.

In cytogenetic membrane we have congestive or vascular forms of inflammation in which we get serous or mucous or sero-purulent exudation. In these types complete return to the normal condition is the rule.

The next form is the exudative form. This is characterized by the quantity and peculiarities of the exudation, which may be serous, sero-mucous or fibrinous, the last-named as in membranous dysmenorrhœa. And they may be stimulated by exanthemata, of which we will cite a case under treatment.

Then we have the ulcerative form, which affects especially the membranous tissue. We may have in this form the swellings of solitary follicles and lymph glands. When we get pus we may always know that the trouble is in the epithelium or the connective tissue, the only two sources of pus.

Next we have the productive form of inflammation, which results in the development of new tissue.

This type of inflammation is of the chronic or sub-acute kind. It is very prolific in the development of connective tissue, when it attacks the adenoid tissue of the uterus. Under an attack of this form of inflammation the whole

uterus may become affected, and through the development of connective tissue become very much hypertrophied. The different forms of polypi are the result of the productive inflammation. Sometimes they arise from the connective tissue of the membrane, sometimes the sub-mucous, and sometimes the glands.

I have thought best to call your attention to the different types of inflammation in a case of corporeal endometritis, for the reason that each type of inflammation attacking the endometrium calls for a different kind of treatment.

What are the predisposing causes of corporeal endometritis? I know of none other than constitutional dyscrasis.

What are the exciting causes? Vaginitis, cervicitis, sub-involution, gonorrhœal infection, enforced sterility, abnormal conditions of placental site, obstruction of the escape of the natural secretions, and it may be caused by neglecting the proper treatment of a lacerated cervix, introduction of stem pessary, introduction of sound without proper anti-septic treatment afterward, use of tents, and eruptive diseases.

What are the symptoms indicating the disease?

Leucorrhœa glossy like starch-water, and sometimes bloody and purulent, disordered menstruation, membranous dysmenorrhœa, and Bennett considers a rusty-colored discharge from the womb a sure sign of metritis.

Tilt considers the signs of pregnancy without a suspension of the menstrual flow as a sure sign of endometritis. Menorrhagia, cessation of flow after three or four days for one day, when flow comes on again. Dysmenorrhœa and in the chronic form membranous dysmenorrhœa. Sterility is usually the result when not the cause of corporeal endometritis.

This picture shows us that in corporeal endometritis almost every function of the uterus is interfered with.

Diagnosis: This may be made out from the symptoms enumerated; the condition of the endometrium, when the

sound is passed as to smoothness of the cavity or pain when the sound is pressed against fundus, or whether blood or blood-streaked mucus follows the withdrawal of the same.

Now having established the fact, beyond a peradventure, that we have a case of corporeal endometritis, how shall we cure it?

There has arisen of late quite a difference of opinion, among noted gynecologists even, as regards local applications to the cavity of the uterus for diseases which alone exist there, and which are less amenable to constitutional remedies than almost any other organ or cavity in the human body.

For one, after years of making such applications I fail to see the danger, provided proper antiseptic means are used when the application itself is not asepsis.

Some distinguished gynecologists say that disease of the cervix and the cavity beyond will get well of itself. If such has been the experience of members of this club, I hope they will not fail to make that experience known and felt here to-night. If such has been your experience, what would you advise in a case of undoubted corporeal granular endometritis with a perfectly healthy os and cervix?

We have a case of simple catarrh of the epithelium of the cavity of the uterus. We have a cavity also with an outlet for its accumulations, and a uterus so constructed that all its contents to be poured out are emptied into this cavity. Therefore I know of no better way to treat its diseases than to correct, as far as possible, all constitutional disturbances and all local irritations and inflammations by internal remedies. But when they fail we must resort to local applications to the endometrium. The catarrhal forms should be treated with such applications as cocaine, tinct. iodine and glycerine, hydrastin, and boracic acid. In some of the cases we have granular formations on the endometrium.

You may destroy these granulations by curetting, but in

almost all cases the same good results may be accomplished and the same separative inflammation established by the application of iodized phenol to the endometrium. In some cases boracic acid injected dry into the cavity of the uterus has a wonderful effect in destroying these granulations, producing constrictions of the uterus and checking hemorrhage.

If after a reasonable time these applications fail to destroy the granulations, you will be obliged to resort to the curette and iodized phenol afterward.

CASE I.—A woman married one year, no children, had scarlet fever, and before leaving the bed had profuse flow, and continued to flow three out of every four weeks for two years, when I was consulted. She was exsanguine and said her strength was all gone. I said to her, "You must have topical applications to the cavity of the uterus or you will never get well." This proposition she refused to listen to, and said if that was all I could do she would have nothing done. Told her I would try remedies if she wished me to, but could not give her the least assurance that they would do her any good.

So for three months I did my best with remedies, and for three more months she continued, as before, to flow three out of every four weeks. The next time she came she was desperate, and I was determined. Finally she decided to go on the table. I dilated the internal os a little, and with the sound explored the cavity of the uterus, when I found quite a large number of granulations which bled quite freely by being touched. As she was such a hard patient to handle, I decided to do two things at once, so I curetted the whole uterine cavity and then applied iodized phenol, full strength, to the whole cavity, and sent her away without medicine. This patient came nearly one hundred miles to be treated, and I did not see her again for three months. When I did see her, I hardly knew her, for she was the very picture of health, and said

she, "I was never better and more regular in my life than I have been since I left your office three months ago." It does not seem possible, at first thought, that one treatment of the endometrium could result in so much lasting good to any one.

CASE II.—Mrs. S. consulted me for uterine trouble. Said she had had a miscarriage two years ago, and from that time had never felt as well as before. Had been having most of the time for two years a slimy, bloody, and mattery discharge. Suffered much pain in menstrual period and flow continued too long. Had lost much flesh and was feeling very weak. Had tried several medicines and several doctors, but neither had done her any good. I insisted upon giving her local treatment or none at all. Examination showed a case of corporal endometritis, and the discharge showed that the trouble was in the epithelium and the connective tissue. After twelve applications of first boracic acid, hydrastin, and glycerine, and finally tinct. of iodine (Churchill's comp.) she was restored to perfect health so far as any uterine trouble was concerned.

CASE III.—Mrs. P., has been suffering for more than a year from menorrhagia and great suffering at every menstrual period. Would hardly get over one period and its effects before she would feel the approaching pains of the next one coming. Examination showed corporal endometritis which dated from a mismanaged miscarriage several years ago. Sound showed uterus enlarged to three and a half inches, walls hypertrophied, fundus so sensitive that the slightest touch of the sound caused her to cry out from the severe pain it produced. Surface rough, more like swollen glands and follicles than like hard granulations. Considerable muco-purulent discharge.

The internal os was dilated with steel sounds and the cavity wiped out with absorbent cotton. After which the whole endometrium was brushed over with iodized phenol and the cotton used for the brushing allowed to remain in

the cavity of the uterus for a few minutes. After the second application the monthly flow was nominal, and, to use her words, "without the slightest pain." This patient has received five treatments since, and the result has been that an anteversion which existed has been cured by reducing the uterus to its nominal size, and with that came its normal position. Sound can now be pressed hard against the fundus of the uterus without causing pain.

The next form we meet with is the ulcerative form, which affects especially the membranous tissue. We may have in this form swelling of the solitary follicles and lymph glands. This form of endometritis calls for about the same course of treatment as the last-mentioned type, with the addition of acetic acid and glycerine, 1 to 3.

Up to the last-named form of endometritis, good may result from the use of such remedies as arsen., bell., graph., hydras., merc., sepia, and many others when judiciously selected. One trouble in selecting remedies for disease of the endometrium is the fact that in most of our text-books they prescribe a remedy and give as its indications the symptoms and pathological conditions that we find in the vagina and in the various forms of disease that attack the cervix. I must confess that applications direct to the endometrium, light or severe, according to indications, have resulted in far more satisfaction to me and far greater benefit to the patient, than any well-studied remedies I have been able to prescribe.

Next and last, we have the productive form of inflammation, which results in the development of new tissue. This type of inflammation is of the chronic or sub-acute kind, and is very prolific in the development of connective tissue. Under an attack of this form of inflammation the whole uterus may become affected, and through the development of connective tissue the whole organ become very much hypertrophied. The different forms of polypi, and also fibroids, are the result of this form of inflammation. In this form of

hypertrophy you must set up what Virchow calls a curative inflammation.

This is accomplished in three ways: by the curette, by the application of strong iodized phenol, and by the introduction into the cavity of the uterus of sulphate of zinc suppositories containing from three to five grains each. In treating these cases, I first deplete the uterus by making several punctures in the cervix, and then keep a continuous stream of hot water against the cervix, until bleeding ceases. In this way I often extract from two to three ounces of blood from the congested and enlarged uterus. After this I dilate with steel sounds and make the application to the endometrium and put in a tampon of glycerine and boracic acid. This tampon I allow to remain from two to four days, when patient is instructed to remove it and follow its removal with an injection of hot water. I not only believe this to be the best way to remove and cure hypertrophy of the body of the uterus, but I believe it is about the only way that it can be done. Again, such treatment as we have described may not only prevent polypi and fibroids of the uterus, but when they are formed this treatment is the surest way to arrest their growth and starve them out by relieving the congestion, thus removing from them the nutrition on which they thrive.

I have given for fibroids alone iodide of lime with apparent good effects, for under it the tumor lessened and finally disappeared. There is still another benefit from making applications to the endometrium, and that is, you may correct versions and flexions—cure dysmenorrhœa and metrorrhagia. Another advantage in arresting this inflammation in the endometrium is that you prevent inflammation of the fallopian tubes, and thereby prevent the exfoliation of the epithelium that lines the tube, thus preventing a bare spot on the tube to which an ovum could adhere and get up tubal pregnancy.

Tait has for some time claimed that so long as the tubes

were healthy and the epithelium was intact, tubal pregnancy could not take place.

Johnson, to whom I have already referred, says, and I think truly, in woman where on account of its erect position the uterus has to depend on the tenacity of its own fibers for the preservation of its own shape, no such thing as loose tissue of a lymphatic network can be depended upon. So to preserve the integrity of the uterine walls, the emulgent stream is poured into the cavity of the body and got rid of through the vagina.

Dr. Johnson's articles are found in the *British Gynaecological Journal*, Part 8, page 324.

It is seldom that I turn to Dr. Southwick's work on gynecology without benefiting my patient, but in a case of corporeal endometritis his carefully selected remedies fail, as all remedies fail, to do the work of topical applications when applied to the uterine cavity and to the whole endometrium. When we have succeeded by depleting the uterus, and by topical applications such as we have already mentioned to the endometrium, in producing contraction in the lax muscular fibers of the uterine walls, we shall have the uterus in its proper place and in its normal position.

CAN LACERATION OF THE PERINEUM BE PREVENTED?

BY SARAH J. LEE, M.D., ROCHESTER, N. Y.

(Read before the New York State Homœopathic Medical Society.)

For the past few years our most prominent accoucheurs have given this subject their best thought, and have been constantly endeavoring to secure some means to prevent laceration of the female perineum during parturition.

I shall not discuss the many methods which have been devised to modify uterine contractions and retard the progress of the head, or yet the various manipulations calculated to expand and support the perineum, as those present

are probably familiar with them. The futility of some is apparent, and the utility of others doubtful, yet I do not deem it the best use of time to dwell upon their merits or demerits.

That the obstetrician often fails to prevent this accident, is clearly shown by the number of patients who come into the hands of the gynæcologists. We are constantly called upon to relieve conditions which we know are the result of a laceration of the perineum. By laceration of the perineum I do not mean a tear in the perineal body alone, but refer also to a separation of the deeper structures which form the pelvic floor, and afford the necessary resistance to the expulsive efforts of the uterus during the second stage of labor.

It is generally conceded that lacerations exist in from 20 to 30 per cent. in primiparæ and from 5 to 10 per cent. in multiparæ. They vary in degree from a mere parting of the fourchette to a complete division of the perineal body, as well as the muscles of the pelvic floor, and often extend into the rectum. Still, there are men who claim to have enjoyed a large obstetrical practice for years, without ever having had a perineum lacerate. Now, I do not wish to be considered an extremist, but if we, as specialists, are to "pay tribute to whom tribute is due," we ought to thank this class of men for many of our patients. The obstetrician who knows how to diagnose lacerations of all degrees, and repairs or causes them to be repaired, is not remiss in his duty. But he who allows his patient to leave the parturient bed, sooner or later to become the victim of those symptoms which make life a burden, certainly is not practicing up to the privileges of the present century.

Can lacerations be prevented? I shall not try to answer this question with a simple yea or nay, but wish to present for your consideration a few facts, which I believe often act as predisposing causes.

First: American women must be taught that they can

not act with utter disregard to the physical laws which govern the reproductive organs; and as long as they have mistaken notions of the origin of diseases peculiar to their sex, we will have not only laceration of the perineum, but scores of other diseases which are so prevalent among them.

Not long ago a patient said to me, "It seems as though all the ailments from which women suffer can be traced to child-bearing, and I, for one, wish I was a man." After making a careful examination, I replied: "You, like many others, are not suffering from any trouble which can be traced to the birth of your only child, but from the abortive means adopted by you, in your determination not to have another."

Now, I have consulted gynæcologists of far more experience than myself, and I find that I am not alone in the opinion that American women are accountable to a large extent for their sufferings. What will be the result, if women retrograde in physical endurance as fast in the future as they have in the past? Is it not a fact that most of them suffer from some disorder of the female genitalia? You need not go to the specialist for an answer in the affirmative. Does not the general practitioner constantly meet symptoms which he is confident are the result of these disorders? After consulting this branch of the medical profession I think I am safe in making the statement, that more women suffer from these disorders than do from the combined primary diseases of lungs, heart, liver, kidneys, and stomach. Notice I am speaking of American women; for such disorders are not nearly as common among classes in which abortion is not practiced, and a goodly number of children are the rule and not the exception.

No doubt some present are wondering what all this has to do with the prevention of lacerations. I answer, *much*.

Give me the training of women from puberty to the climacteric period, and I will show you, in a large majority of cases, those who will pass through gestation and parturition

with approximately as much tolerance and ease as they perform other organic functions.

There is no other organ in the body, the physical laws of which are disregarded as are those governing the uterus and its appendages. We do not expect a disordered and abused stomach to digest our food properly; or a diseased kidney to eliminate healthy urine; or an imperfect heart to propel the blood evenly and accurately over the system. Can we, then expect a uterus, the nerve function of which is so changed as to render it exceedingly sensitive to any stimulus, to expel its contents with as much regularity of muscular contraction as a healthy one would? And is it logical to puzzle our brains for some method to control the "too forcible pains" and retard the progress of the head in order that the perineum may have time to expand, without making an effort to control the cause. Again, uteri which do not maintain their proper position to the straits of the pelvis, throughout gestation, will not suddenly get into line, and thrust the presenting part into the most favorable position for its safe delivery.

Thirdly. The condition of the perineum has much to do with the progress and termination of the second stage of labor. In making digital examination it is not unusual to find the muscles which form the pelvic floor tender and intolerant of manipulation; or hard, unyielding, and inelastic; or too lax to respond readily to reflex excitation.

Every obstetrician knows, or should know, that it is the function of these muscles to retract and resist the expulsive efforts of the uterus, and by their contraction contribute largely to the expansion of the perineum. If any of the above conditions are present, can they be expected to perform their office in a satisfactory manner? We would not expect muscles in other parts of the body to act normally under similar circumstances.

I believe that many lacerations are due to the fact that no effort is made to save the perineum until labor is

established. Often this is the time when the golden opportunity has passed, and our best efforts are but a bungling apology for previous neglect. I do not undervalue the methods of manipulation during the second stage of labor. No doubt the presenting part is sometimes coaxed into a more favorable position, etc.; but this is only correcting a condition which in some cases, at least, need not have existed. Of course I do not refer to those instances in which the head is unyielding, and out of proportion to the pelvis; for no amount of precaution would avail anything under such circumstances, unless the diet theory may have some influence over it. Neither would it apply to congenital malformations of the pelvis.

But it is certain that organs act better in a state of health than when diseased. Therefore, a fruitful means of preventing laceration of the female perineum would be to teach women the hygiene of the generative organs, and thus save them much suffering.

PELVIC CELLULITIS.

BY ELIAS C. PRICE, M.D., BALTIMORE, MD.

(Read before the Investigation Club.)

Pelvic cellulitis, on account of its great prevalence, should claim the careful consideration of the general practitioner as well as the gynæcologist. The general practitioner should be able to recognize its symptoms so as to treat the case, or have it treated, without delay.

As a general rule, I do not recommend frequent examinations in uterine complaints, but pelvic cellulitis constitutes an exception to the rule. Unless you make frequent digital examinations, you can not form an idea in regard to the progress of the disease.

Either the disease was not so frequent among females in

the country thirty or forty years ago as it is among females in the city at the present time, or else physicians were not educated up to the point of being able to recognize it then as they do now. I think both suppositions are correct.

Pelvic cellulitis is an inflammation of the cellular or areolar and adipose tissue, wherever that tissue is found in the vicinity of the uterus and its appendages, viz: "between the layers of the broad ligaments, behind the uterus, in the Douglass pouch, between the uterus and bladder, around the rectum and cervix, in the iliac fossæ, along the psoas muscle, upward toward the kidneys and downward to the gluteal region by the great sciatic notch."

"The most intractable cases arise from injury done to the soft parts by intentional abortion, especially when it is mechanically induced."

"The non-puerperal cellulitis may result from incision of the cervix uteri, amputation of the cervix, ovariectomy, trachelorrhaphy, the ligation of polypi, the excision of hemorrhoids, the operation for vesico- and recto-vaginal fistula and ruptured perineum, the introduction or prolonged retention of the sound or tents of various kinds, or wearing intra-uterine or stem pessaries, the application of caustics, wearing vaginal pessaries too long without removal and cleansing, excessive and too forcible coitus," and another cause, that very few authors mention, but which a French author of a little work called "Preventative Remedies" calls fraudulent connection: the crime for which the Bible says Onan lost his life; also masturbation, the extension of corporal metritis and ovaritis to the areolar tissue, and, rarely, from falls or blows.

West thinks 77 per cent. results from labor or abortion and consecutive inflammation. Gallard and Burntz reduce this estimate to 44 or 45 per cent.

To menstrual disorders are attributed from 10 to 20 per cent. Prof. Courty thinks that one-third of all uterine dis-

eases are due to pelvic cellulitis; while Prof. T. Gaillard Thomas thinks "a very large proportion of the cases now regarded as instances of cellulitis, are really those of pelvic peritonitis."

Prof. Ludlam says: "The clinical history comprises four stages of the affection: (1) that of congestion; (2) effusion and induration; (3) resolution; (4) suppuration. The first or congestive stage may occur a few hours after delivery or after the accident which has induced the attack. It may begin abruptly, and is usually but not always accompanied by a chill," or at least rigors.

"If the congestion is extensive and active, the pelvic reaction will be very decided, the tongue is furred, and there will be more or less nausea and vomiting."

"These symptoms are followed almost immediately by intra-pelvic pain and distress. The location of this pain varies with the seat of the inflammation. If the cellular tissue between the broad ligaments is attacked, the pain will be referred to the corresponding side of the pelvis, in which it will be deep-seated and very severe. If the same tissue surrounding the uterus is the seat of the lesion, the suffering will be in the upper part of the vagina, and contact with this organ, even by the most delicate 'touch,' will be insupportable. If the peritoneum is also inflamed, the pain will be acute and lancinating in character. Most of the pain experienced, however, is ascribed to the pressure of the effused fluid (which has escaped into this tissue) against the neighboring organs. In many cases the bladder, and in others the rectum are thus mechanically pressed upon, giving rise to strangury and tenesmus, which are not relieved by the usual remedies. Very often, more especially after the tumor caused by the effused serum has been formed, the pain is described as throbbing and paroxysmal."

I once had a case that went on to suppuration; the abscess broke into the bladder, and large quantities of matter were discharged with the urine. About the time the pa-

tient seemed to be well, there was a return of the premonitory symptoms, a tumor as large as an ordinary cocoanut formed high up in the other iliac region, violent pain came on every afternoon at five o'clock. Sulph. 30 soon brought the disease to an end by causing resolution. I regarded the first attack as pelvic cellulitis, and the second as pelvic peritonitis.

The pain is "usually not diffused, but local and circumscribed in its extent. In acute cases, the congestive stage is limited to a few hours, while in chronic cases it may continue longer, and is very apt to repeat itself, involving other parts of the same tissue in the successive attacks."

When effusion of serum takes place the acute symptoms are generally relieved; soon after effusion takes place, the serum solidifies, becoming nearly as hard as a fibroid tumor, for which they are easily mistaken by young beginners; they may assume almost any shape or form. The stage of effusion may last from one to several weeks, so may either resolution or suppuration of the tumor advance at a more or less rapid rate; frequently when you think your patient is almost well, you will be surprised by a relapse. I have had three ladies in one family that have been subject to this disease; some twenty years ago a married daughter came to me several times within a period of two or three years, in consequence of the bursting of an abscess in the vagina, then for a period of about 15 years she seldom had any trouble from it; but for two or three years past she has had several attacks. Next the mother had several similar attacks, then for years she had immunity; latterly she has again had two or three attacks. About four or five years ago a single daughter had eight or nine abscesses within twelve months.

In broken-down constitutions recovery is very slow. So it is, also, in the chronic form. Sometimes the bimanual examination will detect fluctuation. At other times the

occurrence of rigors or chills will be the only evidence of suppuration. The abscess may break into the vagina, the rectum, the bladder, the intestines, in the region of the hip, the great trochanter, beneath Poupart's ligament, or into the abdominal cavity; in the latter case death is inevitable.

I have had one case to break into the bladder, and one into the rectum, and numerous cases that broke into the vagina. Prof. Courty has also seen one case that opened into the bladder and one into the rectum.

If the swelling is in the roof of the vagina, the uterus will be fixed; if the swelling is lower down, either anterior, posterior, or lateral, the uterus may be more or less movable. There is generally considerable sensibility to the "touch." If the disease is located in either iliac fossa, the leg on the side affected is generally flexed.

When pelvic cellulitis results from an early abortion in a young married woman, it is very apt to be followed by sterility. It is often complicated with pelvic peritonitis, or ovarian disease.

If the tumor forms in the posterior cul-de-sac the young practitioner is very liable to mistake it for retroflexion and adhesion of the uterus, or for a fibroid tumor attached to the posterior part of the uterus. The sound will clear up the diagnosis. It may be mistaken for pelvic hæmatocele, but the rapid formation of the tumor, and the symptoms of sinking and collapse, in the latter case, are absent in pelvic cellulitis.

I mistook three of my earlier cases for retroflexion and adhesion of the uterus, but I found myself in good company. The first homœopathic literature I saw on displacements of the uterus was an article published in pamphlet form and read by our friend E. M. Hale, M.D., before the Illinois State Medical Association, May 18, 1864, "On the Therapeutics of Retroflexion and Retroversion of the Uterus."

Dr. Hale gives a very concise description of the symptoms and treatment of the above displacements; with that part of the pamphlet I have no controversy. But Dr. Preston's case, published on page 16, is, without the shadow of a doubt, a case (and a very severe one too) of pelvic cellulitis. Dr. Preston says: "I transcribe the case, as I then reported it, without troubling you with a list of fifteen or twenty cases, all very nearly alike, in constitution, in actual displacements of the uterus, and its results." He then says, "On the 29th of Aug., 1849, I was called to see Mrs. S., aged 44, a widow, etc." After giving her history from her childhood up, he comes to the case in point. He says: "She could not walk across the room, in fact could not stand erect, without a most disagreeable sensation of pressure and protrusion of the rectum. . . . I proposed and made a careful examination per vaginam and per rectum, with the finger and afterward with the speculum, and found the womb at that time *much swollen, hard and very sensitive to the touch*; it was at least *four times its natural size and very much inflamed*; besides it exhibited decided retroversion, the top of the fundus rested on the rectum. From what I could learn of her symptoms previously, I have no doubt but that a similar condition had existed several times before, and had been treated for dysentery; on these occasions she had neuralgic and hysteric spasms quite severe, constant tenesmus, and white, slimy evacuations occurring every four or five hours; *a considerable sympathetic fever, much tenderness of the abdomen, urine high-colored and scanty*, a very disagreeable and painful downward pressure, which she felt high up in the rectum, with other symptoms indicating the same pathological disturbance. I prescribed several remedies for the *inflammatory condition of the womb and rectum* (the italics are mine), which relieved all the more severe and acute sufferings. Acon., bell., merc., calc., sulph., sepia, and sabina were the chief remedies used, and all successful in combating the

symptoms for which they were given ; but after the dysenteric discharges and all the more severe symptoms had been checked, and the womb had been reduced as nearly to its normal size as could be expected in the critical period, there still remained the same displacement and the same disagreeable pressure on the rectum. An examination satisfied me that the womb was restored to its natural size, and that all the tenderness of the womb and rectum had disappeared, but the retroversion was more prominent, and the uterus was actually doubled up, so that in the vagina the finger could feel the fundus and the os tincæ on a level." (So I once thought in one of my cases, but on passing the sound I found the uterus in its normal position, and the supposed fundus to be a swelling on the posterior part of the uterus which disappeared in a few days.) "I then put her on ferrum iodatum 1st trit.; within a week she improved wonderfully ; she was able to stand erect and walk about her room, and was relieved of much of that pressure in the rectum which she had so long experienced. I persevered in the use of ferrum iodatum for two months, varying the potency from the first to the third, and alternating the two weekly ; the inflammation had been so severe and of so long continuance, that adhesions had taken place between the peritoneal covering of the womb and rectum, so that *the fundus could never assume its true normal position*" (italics mine again), "but it was very much improved, and the pressure on the rectum removed ; about three months after she had been under my care, she menstruated freely and naturally, her general health improved, and up to this time she has remained quite well, has had no return of uterine trouble, and has to all appearance passed the critical period in safety."—*Philadelphia Journal of Homœopathy*, vol. i., page 462.

Dr. Preston's mistake in diagnosing a case of pelvic cellulitis as a case of retroflexion led me to make the same mistake. It would be interesting to know how many of

his fifteen or twenty other cases were really cases of pelvic cellulitis.

Two of my cases that I had diagnosed as retroflexion I endeavored to replace with Dr. Guernsey's uterine elevator. After giving my patients an awful amount of pain I concluded that "adhesions had formed," and desisted. After treating them somewhat in accordance with Dr. Preston's plan one became well enough to dispense with my services. Though I see her occasionally, I have never prescribed for her since. She looks very well. The other patient I had occasion to examine about two years afterward: the womb had returned to its normal size and position, if it had ever been out of it, which I now very much doubt. The first one of the two above-mentioned cases came into my hands after the sudden death of her allopathic medical attendant, who had been treating her for about a week or more, for inflammation of the bladder.

PROGNOSIS.—The prognosis is generally favorable, though death may result from the occurrence of peritonitis, long continued suppuration, or abdominal tuberculosis, or from the abscess bursting into the abdominal cavity.

Be very careful about performing surgical operations of the most trifling kind, even the introduction of a tent or a sound, after the patient has had an attack of pelvic cellulitis. To make a rapid cure of a case of acute pelvic cellulitis, it is as necessary to confine the patient to a horizontal position as if she had a broken leg. If a married woman, the marital relation should cease; coughing and constipation should be avoided if possible. During warm weather, if the patient is swung in a hammock it will often promote sleep; of all local applications, probably the copious vaginal injection of hot water is the best.

TREATMENT.—If we wish to be successful we must individualize each case. Routine or pathological treatment are both frequently deceptive. In about sixteen months, including parts of the years 1886 and 1887, I had sixteen

cases under my treatment. I have administered *lilium tigrinum* 3d and 4th dec. dil., more frequently than any other remedy. The next in frequency of administration is bell. The other important remedies are ver. vir., bry., apis, acon., canth., arn., lach., *cimicifuga*, hepar, merc., sil., calc. c., coloc., tart. em., terebinth., and conium mac.

Lilium tig.—Either anteversion or retroversion of the uterus, which is very low down in the vagina. Painful sensation of bearing down in the region of the womb, as if the whole pelvic contents would issue through the vagina, if not prevented by pressure upward with the hand against the vulva, or by sitting down. Pain in uterine region as if the menses were coming on. There may be pains in the ovaries or uterine region, or in both, which are of any degree of intensity, from dull to sharp, but chiefly sharp. Both ovaries are affected, but the right most frequently.

The ovarian pains radiate from the ovary in any direction but most frequently across the abdomen. They are relieved by moderate pressure upon the ovary, and aggravated by motion. Burning or cutting pain in the region of the ovaries; the cutting pain extends down into the groin and anterior part of the thigh. Thin, acrid, excoriating, brown, or yellowish leucorrhœa, followed by swelling, soreness, or a rash upon the parts. Intermittent menses, after flowing twenty-four hours, cease for twelve hours, then return. Menses came on again in two weeks. Increased sexual desire in women. Increased inclination to urinate, must rise twenty times in the night for that purpose. Milky urine.

Belladonna.—Bearing down in the sexual organs as if everything would fall out there; worse on sitting bent and on walking, better when standing and sitting erect. May have the bell. headache, nervousness and starting when about to fall asleep; if the attack comes on after erysipelas, or if there is much congestion, dryness of the throat and fauces, dilated pupils, redness and heat of the face. Burn-

ing in the region of the uterus or ovaries, lancinating pains, ovaritis or enlargement of right ovary. Bright red, premature and profuse menses, or else dark and offensive. If occurring after parturition the lochia may smell offensive and feel hot to the parts.

Verat vir. is a precious remedy in the early stage of pelvic cellulitis. For a knowledge of this remedy in this disease we owe a debt of gratitude to Burt, Ludlam and others. There may be a full, bounding pulse with hot skin, or a slow, weak, intermitting pulse with a cold skin. Hyperæmia of the brain with nausea or vomiting when rising the head. Congestion, swelling and tenderness of the parts around the cervix, etc., five drops of the second decimal dilution given in water every two hours is generally sufficient, and I have never known it to have any prostrating effects.

During the winter I had several cases complicated with bronchial catarrh which was then prevailing as an epidemic, for which bry. was the simillimum. It acted equally well upon both diseases.

Apis mellifica is indicated in cases where there is scanty secretion of urine, with an effusion of serum in the cellular tissue of any part of the body; therefore it is particularly applicable during the first stage, or stage of effusion, if the physician has the good fortune to see the case in that stage, though it is not without value after consolidation has taken place. Burning or stinging pain in the right iliac or ovarian region, and uterine tenderness, are additional indications. Amenorrhœa is sometimes present.

Colocynth.—When there are sharp colic-like pains in the region of the ovaries, and decided symptoms of pelvic peritonitis.

Hepar Sulphuris Calc.—When suppuration is threatened or has already taken place.

Lachesis.—If suppuration appears to have taken place in the region of the right ovary.

Silicea.—For long continued, profuse and debilitating supuration, also when there are fistulous openings into the rectum, bladder or other parts.

Tart. em. 3d dec. trit. 3 grs. three or four times a day, generally removes patches of induration if they are not too extensive, nor too firm in their texture—Ludlam.

Phosphorus.—If the location of the pain should indicate that the left broad ligament is the seat of the disease, with pain extending down the inner side of the thigh.

Podophyllum.—Pain in the region of the ovaries, especially the right, or aching pain in region of the left ovary, with heat running down left thigh.

Differential symptoms in regard to the bearing-down sensations of different remedies :

Asterias rubes.—General feeling of distress in the womb, as though something were pushing out (G.).

Belladonna.—Pressure as though all the contents of the abdomen would issue through the genital organs (Guernsey).

Lilium tig.—Sensation as if she were being dragged downward in the abdomen. Dragging from the chest and shoulders. Bearing down in the region of the womb, as if the contents of the abdomen would be pressed out through the vagina if not supported (G.). Dragging-down sensation from breasts and umbilicus.

Nitric acid.—Violent pain as if everything were coming out of the vulva, with pain in the small of the back, through the hips and down the thighs.

Nux vom.—Prolapsus uteri from straining or light pressure toward the genital organs early in the morning, in bed, or during a walk, with a sensation of contraction of the abdomen.

Sepia.—Pressing in the uterus, oppressing the breathing; sensation as if everything would come out the vagina; she had to cross the limbs to prevent it.

A CONTINUATION OF THE SERIES OF STUDIES OF NEW REMEDIES IN GYNÆCOLOGY—POLY- GONUM HYDROPIPERGIDES.

BY PHIL. PORTER, M.D., DETROIT, MICH.

Synonyms, Polygonum Mite; *Natural Order*, Polygonaceæ; *Common Name*, Mild Water Pepper. Like many other remedies, polygon has been first labeled an emmenagogue, and then laid away on the shelf by the old school because it did not relieve every case. Eberle, who introduced it in his work on *Materia Medica and Therapeutics*, derived his knowledge of it from a country practitioner who made it a subject of his thesis as a candidate for the doctorate at the medical school, where Eberle held the chair of practice.

It has a direct affinity for the mucous surfaces, the nervous system and fibrous tissues, and also for the urinary apparatus. Dr. J. K. Shirk, in calling attention to the remedy, says it has a special affinity for the female reproductive organs. In this he is borne out by the facts, that it restores suppressed menstruation without producing any disturbance or alteration of the general system (in large doses), and that it acts curatively in cases of chronic disease of the uterus and ovaries, and relieves many of the subjective symptoms due to these disorders.

As an emmenagogue it acts in large doses by increasing the blood-supply to the pelvic viscera, in states of anæmia, functional torpor of the ovaries and uterus due to systemic depression. From the physiological action we may draw the inference that it will act homœopathically in menorrhagia and metrorrhagia due to relaxation of the uterine vessels. Subinvolution, with passive congestion, cold hands and feet and general depression, are also benefited by Polygonum Hydropiper. Dr. I. J. Goss recommends it in bladder affections connected with loss of

expulsive power: also in suppression of urine with stranguery. It is especially in paralysis of the bladder from distension that it proves successful.

INVERSION OF THE UTERUS.

BY J. H. SHERMAN, M.D., BOSTON.

April 14, 1888, was called in consultation with Dr. Packard at 69 G Street. in a case of difficult labor. The doctor stated that there seemed to be plenty of room but the pains were faulty, and as he had awaited an hour or more with no perceptible progress, thought it advisable to use the forceps. He did not like to use them himself, as he was just recovering from an attack of pulmonary hemorrhage caused by holding a frightened horse. I found the head in the inferior strait, right occipital position, applied the forceps without difficulty, and easily delivered her of a very large child. I should have stated that previous to applying the forceps the doctor told me that at her previous confinement, this being her second according to information obtained from the husband, she was attended by Dr. Cushing, of Brookline, who called in counsel in consequence of inversion of the uterus following delivery. I remarked that inversion of the uterus was something to read about but which rarely occurred according to my experience, having never seen a case or known of one happening with any of my friends in the profession. He remarked that he had never seen a case either. But having this in mind I used more than usual care in securing the placenta by expression. There was some delay in delivering the placenta, which seemed due to faulty uterine contraction and I asked Dr. P. to make a little pressure upon the uterus to facilitate expression, while I made slight traction upon the cord, holding it in my left hand, while with my right I inserted my fingers up along the side of the placenta to assist in the delivery. It was

but a few minutes and without much difficulty before the third stage of labor was completed, and then the patient was made comfortable in bed. Standing by the bedside I heard a gurgling sound as if blood was gushing from the vagina. I immediately made an examination and found a pool of blood in the bed. Passing my hand into the vagina was much surprised to find there the inverted uterus. The patient was still partially under the influence of ether, and I requested the doctor to crowd the ether. When sufficiently etherized, I grasped the womb in my hand and carried it at once into place, it turning upon itself as I carried it upward with firm hold upon the fundus. There was no further trouble, and the patient made a good recovery in the usual time.

AMERICAN VS. EUROPEAN OBSTETRICY.

BY GEO. B. PECK, A.M., M.D., PROVIDENCE, R. I.

(Read before the Homœopathic Medical Society of the State of New York.)

Few to-day question the accuracy of that famous assertion of Napoleon I., a country's greatest need is *mothers*! To no other nation is the truth more apposite than to that whose government is by the people for the people. It then can be no idle curiosity which prompts the inquiry, Has transplantation influenced in any manner the adaptability of woman for maternity? Have the changes of environment and of treatment enhanced or diminished its perils? With the hope of shedding some light upon this subject the following comparison has been instituted.

My estimate of the capabilities of American women (and by American women I mean those of European extraction at least twice removed) is based on the facts revealed concerning them during an investigation, continued through nine years, of their peculiarities as encountered by members of the American Institute of Homœopathy in their

professional careers. Data supplied from extraneous sources have been so limited as to be entirely inconsequential. In every case such testimony has been subjected to the most rigid scrutiny, and wherever there has been any occasion for decision or division the burden has been thrown upon them. If in any particular the statement varies from absolute accuracy it is toward the side prejudicial to their physiological character: consequently the actuality will be found to be better than the delineation. The particular form in which any fact concerning them may be stated was determined by its availability for prompt comparison with the statements of recognized authorities.

Not less in accord with the fitness of things than with the laws of gravitation and of mechanics is the circumstance that that being whose strength and power resides exclusively in the brain reveals first its size and contour as he appears on the stage of independent existence. Gratifying is it to discover, therefore, that among that people who account intellect everything and pedigree nothing, in 95.6 per cent. of all births nature accomplishes her perfect work and vertex presentations obtain. The highest proportion reported by any single observer that has come to my notice, is 93 per cent. by Depaul. Spiegelberg, by the collation of private practices, attained a fraction over 97 per cent. It follows, therefore, that the clientelages referred to must have been most select, far removed in social position from hospital frequenters. My impression is that I have seen somewhere that a general collator found the grand European percentage to be 95. Scandinavia and other northern countries usually omitted were included in this calculation. The physical benefits accruing from immigration thence are, therefore, no less striking and important than the intellectual and the moral.

Breech presentations rank second in order of frequency among our native women. They occur once in 47 confinements. On the continent most accoucheurs have met them

once in some 30 cases, though Depaul found one in every 26 cases, and Hecker, in a very limited number of accouchements one only in 84. Milne of Edinburgh gives the rate as one in 60, but without particulars. The amplitude of American pelves and the rarity of multiple pregnancies sufficiently account for the happy escape of so many of our women from this complication.

Face presentations with us as with others occupy the third position: the proportion of such births, however, is far greater here than abroad. There the average ranges according to the observer from one case in 247 births, to one in 147, while my correspondents have met them as often as once in 70. This remarkable excess is readily accounted for: the cause is the price of one charm of American femininity. Delicacy of organization may not be incompatible with gutta-percha uteri and leathern abdominal parietes, but ordinarily they are dissociated. Still, laxity of tissue in our ladies will never impel the intelligent to seek a life companion among the associates of their laundress and janitress.

Of trunk presentation, some recognize two varieties, as the shoulder when only that portion of the body descends, or a single elbow or hand, and the cross when a middle part of the trunk is engaged or a hand and foot simultaneously. The former occurs once in 180 cases, the latter once in 310; combining we find a trunk presentation once in 114 cases. Across the pond it is looked for anywhere from the 115th to the 125th, although one gentleman found it in every 86th. Pelvic amplitude and structural elasticity abundantly explain the existence of this complication.

Brief reference to multiple pregnancies is not out of place. In England the accoucheur meets twins at the 63d confinement, in Germany at the 84th, and in France at the 92d, but among our native women they are not found until the 107th. Triplets appear once each in 4311 English child-beds, 7182 Germany, 7388 American, and 11,105

French. Quadruplets are strangers practically to French and to American families. The notorious excess of supply to demand in the matter of babes, especially in our towns and our cities, renders the seeking of other causes for the apparent infecundity of our women a work of super-erogation.

The mechanical complications of parturition may well be grouped together irrespective of time and cause of manifestation, although the natural order will be followed as closely as possible.

Accidental hemorrhage occurs once in 1638 pregnancies, with a natural mortality of 5.558 and an infantile considerably greater. A Scotch authority places the maternal death-rate at 13.239.

Placenta prævia is found in American women once in 1300 confinements. Including all varieties the maternal mortality is 8.88 per cent. and the infantile 35.55 per cent; but if we regard only the partial, the maternal is only 1.75 per cent. and the infantile 19.3 per cent. Charpentier gives the maternal death-rate as varying from 25 per cent. to 32 per cent. and the foetal from 56.91 per cent. to 68.87 per cent., but his translator interpolates a couple of pages abstracting Lomer's of Berlin paper, in the *American Journal of Obstetrics* for December, 1884, which reports a mortality of 4.5 per cent. only. Let it be remembered, however, not only here but continuously through the comparison, that the general practitioners whose experience is the exclusive basis of this report were often separated by miles of rough road from their patients, that frequently the unfortunate women were apparently moribund upon their arrival, and that when ready for work the physicians were obliged to content themselves with such conveniences and such assistance as were at hand. For information concerning the method by which they achieved their success, consult the Transactions of the American Institute of Homœopathy, session of 1880, pages 423-431, reading "extrusion,"

for "extension" in the sixth line of page 429, and omitting the first "and" in the sixteenth line of the same page.

Forceps are resorted to by our practitioners in 10.5 per cent. of their confinements. At the Paris Clinic from 1852 to 1880 they were employed only in 2.7 per cent. of the labors, and at the Maternité from 1848 to 1877 but in 1.27 per cent. Furthermore, among 83 German, Russian and Swiss maternities and clinics, during various years from 1779 to 1865, in only eight places were they called into requisition oftener than with us. The epoch determines nothing, for the earliest operator was surpassed in the frequency of their employment by thirteen only. The general average of the entire number is but 3.29 per cent. Finally of 28 British establishments between the years 1803 and 1862, in one only were the forceps used more frequently than among us, and in but one other anything like so often; the third employs them only in $3\frac{1}{4}$ per cent. of his cases, while the general average of all authorities is but $\frac{1}{4}$ per cent. Whether this European infrequency is due to the toughness of the women or the greater toughness of the doctors I will leave for others to indicate. Certain it is that American women with their higher nervous development can not abide by such neglect, and ought not. He who stands idly near and allows his conscious or unconscious patient to continue in travail, when by a judicious use of the forceps she can be delivered promptly, safely, and pleasantly, is a brute! Proverbial keenness of insight and readiness of adaptability have already served not only the American profession but especially its patients a good turn, although there is room for improvement in certain quarters. Note Institute Transactions 1882, page 425.

Parenthetically it may here be remarked that some anæsthetic is regularly employed in the lying-in chamber by 84.56 per cent. of our physicians, though the frequency of its use varies with the individual from "rarely" to "almost

always." Chloroform has twice as many devotees as ether: a very few mix them.

Turning is accomplished by us once in 103 confinements, by the Germans once in 88, by the French once in 110, and by the English once in 113. In the Paris Clinic between 1852 and 1880 it was performed once in 126 cases; in sundry German, Swiss, and Russian maternities from 1789 to 1865 once in 88, and Sichel reports that in nearly half a million of births it was effected once in 118 cases. I have no figures bearing on the mortality following this procedure, but my impression is that if timely executed, and ordinarily skillfully, the mother's safety is practically unimpaired, and the infant's risk increased only to that of ordinary breech presentations.

Craniotomy, by which term I mean the more or less complete destruction of the foetal head irrespective of the means employed, has been resorted to once in 879 labors, with a maternal mortality of 8.7 per cent. Decided preference is shown for the cranioclast, the cephalotribe being used only two-thirds as often, and then in many instances with disfavor. In German maternities the operation has been performed once in 540 labors. The mortality at the *Clinique* from 1852 to 1880 from cephalotripsy was 29 per cent. and a series of 122 similar operations by others gives a death-rate of 38.52 per cent. Simpson's, the inventor's, loss with the cranioclast was 20 per cent., although Fritsch reduced it to 17 per cent. and Bidder from 1873 to 1875 used the instrument thirty-two times successfully! The plenitude of deformed pelves across the pond explains at once the greater frequency there of this and kindred operations, and the heavier mortality. It may well be observed in this connection that the cranioclast should be used in all cases where there is a liability of injuring unduly the parturient canal through the intensity of the force requisite to extract a foetal head with forceps. The well-authenticated anecdotes that occasionally come to our notice, of wonderful

gymnastic feats at the lying-in bedside by groups of muscular and ponderous men, are alike unseemly and barbarous.

Requiring only passing mention are the facts that evisceration (destruction of the foetal body) has been required only once in 12,956 cases, and decapitation once in 51,825, all being accomplished without maternal loss. Caesarian section was resorted to once in 12,956: the mortality was heavy. People prefer deferring radical methods of treatment until their friends are moribund.

Rupture of the uterus is met with once in 9077 cases when consultation practice is included in the calculation, but only once in 24,951 if private cases alone are considered. The prognosis is grave and is largely dependent on the promptness with which the services of a skillful surgeon can be secured. In Europe the accident occurs once in from 3402 to 940 accouchements. Our comparative exemption is to be ascribed chiefly to the greater preponderance of normal pelves, to the earlier resort to forceps, and to the infrequent use of ergot. Moreover Americans are not given to beating and kicking their wives.

Inversion of the uterus was encountered once in 3319 labors, two-thirds of the cases being consultations. Of the entire number four-ninths were complete and five-ninths partial. The mortality was 14.82 per cent., occurring entirely among the consultations. The prognosis is not serious, provided the accoucheur has sense enough to recognize the accident and sufficient presence of mind at once to remedy it. While it can not be denied that a fraction of the cases are due to the ignorance or stupidity of the attendant (often but not always an illiterate mid-wife a considerable portion occur spontaneously and result from the excessive development of nerve tissue as compared with muscular.

Thrombosis of the labia has been found once in 7470 cases. It is possible but not probable that death will

result. Across the water it varies in frequency from one in 467 labors to one in 1800. Thrombosis of the nobler organs (brain, heart, or lungs) we have met once in 14,104 confinements. The entrance of air into the circulatory system has not been noticed.

Brief attention to the more common complications of gestation and parturition ordinarily considered susceptible to medication may repay us by throwing light on the health of our women and on their strength of constitution.

Hysteria has been treated in child-bearing women by 27 per cent. of our physicians without resulting evil, and 10 per cent. have treated epilepsy in the same class without damage to the mother and a mortality to the foetus of only 7 per cent. Their experience thus corroborates the statement of Charpentier that the influence of these disorders on pregnancy is practically *nil*. On the contrary, 10 per cent. of my correspondents have treated ladies suffering from chorea without supervening damage, while the author just cited gives the number of miscarriages and premature births as ranging from 33 per cent. to 58 per cent., and the maternal mortality as from 29 per cent. to 35 per cent., some being undelivered.

Cardiac difficulties have obtruded themselves upon the notice of but 89 per cent. of our physicians. These report simply an infantile mortality of 25 per cent. The only European authority at hand gives a maternal mortality of 37 per cent., one-sixth of whom died before delivery: the foetal loss was unmentioned. For a lucid exposition of the cause of this terrible loss of mothers see Sturtevant's discussion of this subject in the Institute Transactions of 1888. Similar arraignments might be made of the "scientific" treatment of other disorders mentioned in this section.

Measles have been found to be innocuous to gravid *women* on both sides of the Atlantic. Two Europeans give their percentage of abortions and premature births as upwards of fifty, and two others state these occur "almost always."

Our loss is but 25 per cent. Eight physicians in every hundred have treated this complication, indicating a far greater prevalence of the disease in this class than obtains abroad.

Scarlatina, Charpentier affirms, "terminates in abortion in the case of every woman, in death in the majority." He also states that, "although not absolutely rare among the complications of labor," it is "the exception during pregnancy." Six per cent. of our practitioners have treated the disorder coincident with gestation, and lost but 9 per cent. of the mothers and 18 per cent. of the children. Seven per cent. have treated it during the puerperal state, with a loss of 62 per cent. of the unfortunate women.

Variola has been observed in the enceinte more frequently than other eruptive fevers, 10 per cent. of our physicians reporting cases with a maternal loss of 15.39 per cent., and a foetal of 46.15 per cent. (Kindly change at once the figures in the paragraph treating of this subject on page 397 of the Institute Transactions for 1887.) Two series of European cases have come to my notice, in one of which 17.2 per cent. of the mothers died, 31 per cent. aborting, and in the other 38.2 per cent. died, 46.8 per cent. aborting.

Typhoid fever has occasioned the death of 12 per cent. of the pregnant women who suffered from its infection under the observation of every tenth of our practitioners, and 24 per cent. of the infants. Charpentier reports miscarriages in 52.8 per cent. of such women, and premature labors in 4 per cent., or taking into account the very slight probability of the survival of any of these untimely adventists as indicated by himself, the total infantile death-rate is at least 55 per cent., and more probably 56 per cent. He naively adds: "The prognosis as regards the mother is more favorable." So mote it be!

Malaria in the enciente has been found to be attended with *no serious* consequences by the 23 per cent. of our number who have prescribed for such ladies. Across the pond pregnancy is interrupted in 41.39 per cent. of similar cases.

Pneumonia has been attended with a loss of 14.28 per cent. to mothers and to offspring (not always two deaths in a single case by any means), in the hands of the 19 per cent. of our physicians who have attended them. In Europe "Statistics presented by authorities correspond in fact to every period of pregnancy, and the important fact deduced from these observations is that pneumonia almost certainly causes abortion, and that a considerable number of women die." Five savants lost 21.1 per cent., 35.8 per cent., 39 per cent., 75 per cent., and 92.8 per cent. respectively. Three of these give their miscarriages as 48 per cent., 60 per cent., and 66 per cent., without specifying the condition of those born at term.

Of consumptives who become pregnant it is probable 25 per cent. will die during the year following delivery. Across the water 64 per cent. have died within that time. Of the children 13 per cent. will perish during the first year, but 50 per cent. will attain middle life here, while there only 37½ per cent. of such children maintained good health, 62½ became scrofulous, and 23 per cent. died of tuberculosis alone before attaining the seventh year.

Eclampsia is met with in this country once in 276 confinements, in Europe once in 354. With us the maternal mortality has been 22½ per cent.; there nine authorities range from 24 per cent. to 55 per cent., a tenth has lost only 22 per cent., and two others only 16 per cent. each. Special success, however, is ascribed to the use of chloral, the claim being set forth that by its exclusive use the death-rate is reduced to 4 per cent., and even when employed after or with other instrumentalities the loss is only 8.49 per cent. Our infantile loss is 33½ per cent., there it ranges from 45 per cent. to 53.34 per cent. Only a portion of my cases were reported so as to render them available for the next comparison, but if patients are divided into three classes, according as the attack supervenes before, during, or after labor, our mortality is 40 per cent., 26½ per cent., and 18 per

cent. respectively against 38.46 per cent., 31.74 per cent. and 32.26 per cent. across the tide. Our infantile mortality is 80 per cent. and 30 per cent. for the first and second classes against 60 per cent. and 37 per cent. These figures demand careful consideration. If the immediate occasion of puerperal convulsions is the presence in the circulatory system of an abnormal substance chemically, mechanically, or otherwise irritant to the nervous system, as certain common, well-nigh inevitable symptoms indicate, is it not our duty as disciples of Hahnemann to render the organism proof against its influence until the poison shall have been eliminated through the channel by appropriate medication? Compare the Organon, § 7, and note with other sections of the same work.

Puerperal fever has been found 99 times as a sequela of 43,322 confinements. From this disorder 31 deaths ensued directly or indirectly. Hence we have an average frequency of one case in 438 labors, one death in 1398, and a mortality of 31.3 per cent. The death-rate according to the total number of confinements is 0.072 per cent. Exact pertinent European statistics I do not have at hand. In one of their best-equipped institutions, however, there is a loss of 8 per cent. of the entire number of their patients from this cause. One gentleman who had only five cases in 4000 confinements covering a period of 40 years is justly held up as an example.

Practical conclusions: First—When I take unto myself a wife it will be some thoroughbred American girl, *if she will have me!* Second—Not only she, but all others, myself included, will be treated with the best of my ability in accordance with the principles of specific medication, that medication which consists in the administration of a single definite drug (in such form as may commend itself to the prescriber), for a given group of pathological phenomena wherever and whenever found, provided, said phenomena are not due to the presence of mechanical or chemical causes. Any departure therefrom may be ascribed to ignorance of

that which I am morally obliged to know. Third—Whenever I find myself in a scrape that I can not clearly see my way out of, I will unhesitatingly call for assistance upon my fellows, knowing full well that I readily can go farther and fare worse—or at least my patients would !

ON THE MANAGEMENT OF PREGNANCY.

BY A. C. COWPERTHWAIT, M.D., IOWA CITY.

A paper under the above title, which might not inappropriately have been called the *mis*-management of pregnancy, appears in the *British Medical Journal* of recent issue, and has been extensively copied in this country. Dr. Sale, the author, states :

“In those patients in whom it might be suspected that post-partum hemorrhage would occur at delivery, such drugs should be given as will act as vascular tonic, among the most valuable of which are the oils of eriganum and of turpentine. The former has a more prolonged effect, and does not, like the latter, produce renal hyperæmia. If these drugs cause irritation of the digestive tract, the liquid extract of matico may be used, and will be found little inferior to them. Several other drugs also seem to act as direct tonics to the uterus, among which are stylosanthus, the most valuable, salix niger, actæa racemosa. Daily faradization is also useful.”

I will say, (1) that I do not believe it is possible to predict post-partum hemorrhage with any degree of certainty, and, therefore, any drugs prescribed upon anticipated physiological indications will, in most instances, at least, do more harm than good. I believe that oil of eriganum (I suppose that erigeron is meant), turpentine, or any of the drugs referred to by Dr. Sale, given in physiological doses for any length of time before parturition, would be much more apt to cause post-partum hemorrhage than to prevent it.

2. If post-partum hemorrhage is feared, the prediction

must be based upon some unusual departure from health—some symptoms present which ought not to be. These should be combated with the indicated remedy, whatever that might be, and thus hemorrhage *or any other* post-partum trouble will be prevented with greater certainty than by any other method.

3. I believe “daily faradization” at any stage of pregnancy to be a dangerous proceeding.

4. I do not believe that “late ligature of the cord” as is asserted later on, has anything to do with post-partum hemorrhage one way or the other.

5. And keeping “the hand on the fundus uteri from the time the head passes the vulva until one hour after delivery is completed,” (another assertion) is even more absurd than the statement that “the rubbing of the fundus uteri through the abdominal wall twice daily, for two days, is safe and useful.” These statements are not deserving of criticism. On the whole, Dr. Sale’s article is no credit to himself, to the gentlemen from whom he quotes, or to the “rational school” of medicine to which all these gentlemen belong. There is nothing either rational or sensible about it.

UTERINE HEMORRHAGE.*

BY A. M. CASH, M.D., TORQUAY, ENG.

Cases of hemorrhage from the female genital organs occur frequently in practice, and are as a general rule successfully treated by homœopathy. The general practitioner has not, it would seem, a very favorable opinion of the action of medicines in these cases. Matthews Duncan speaks in his “Diseases of Women” not very encouragingly. He says ergot stands first; after it sulphuric acid in large doses. Of gallic and tannic acids he speaks as not being sure that they have any effect at all. Duncan says of ergot that we must

* Read before the British Homœopathic Society.

not expect it to act thoroughly till some days of its use have elapsed. This may be so in the ordinary allopathic dosage, but I suspect that few of us using its homœopathic analogue *secale* would expect to wait so long for a favorable issue. We have all again and again seen this drug in the 2d and 3d-dil. rapidly check an alarming hemorrhage from the womb, and when it is indicated, hours, and not days, will suffice to declare a favorable result. *Secale* is only one of many remedies which we can have recourse to. *Sabina*, *bell.*, *ipecac.*, *calc. c.*, *puls.*, *chin.*, *hamamelis*, *viburnum op.*, *trillium pendulum*, *actæa rac.*, *crocus*, *platinum*, etc., are all potent in their sphere. In fact, I believe the homœopathic practitioner will so frequently succeed in curing cases of menorrhagia and metrorrhagia that come to him by these and other medicines, that the chances are he may be tempted to trust to them too much, and neglect such physical examination as would help him to make a more complete diagnosis and such other methods of treatment as may advantageously be employed at the same time.

In the subject under discussion, hemorrhage is only a symptom—it is not the disease itself. Nevertheless it is the chief thing, and if we can cure it we shall probably only do so by curing the disease—that is, the state or condition upon which it depends. Now, if small doses of a homœopathically-acting medicine will do this, we can wish for nothing better. It is our *beau idéal* of homœopathic treatment to cure the disease by treating the symptoms or totality of symptoms to which the disease gives rise; but in practice we do not always find this possible. Hæmorrhages, apparently very successfully treated at first, have often an unfortunate tendency to recur, and my experience is that, when we meet with these recurrent cases, it is wise not to delay making a physical examination, which then often gives precision to the treatment by clearing up the cause. For instance, three cases now under my care com-

plained of hemorrhage. The loss was very different in character in each case. One had it very slightly; with her it was not a prominent symptom. In the second case it was profuse, but only at the menses. The third had it so freely and irregularly that it was impossible to know whether, and if so when, the flow was accompanied by true ovulation at all. Now, all these women suffered from the same cause. Each one had a sore varying from an erosion to a decided loss of substance or ulceration of the cervix uteri.

Sepia, calc. carb., ac. nitric, etc., were the remedies used, but in each conjoined with internal treatment—*hydrastis*, *hamamelis*, and *calendula* injections, and topical applications from time to time of these and occasionally stronger agents, such as ac. carbolico pur. and lunar caustic.

These substances I have just named, viz., *hydrastis*, *hamamelis*, and *calendula*, are most valuable in gynecological practice, and are as a rule very much better than the severe caustics commonly in vogue, whose use should be restricted to turning unhealthy into healthy sores, which are then better treated by the former. I say, then, examine early if in the least doubt. Make a vaginal examination first with the finger, then insert a speculum, of which I prefer a Fergusson. This will generally be sufficient to clear up the case. If not, pass the uterine sound, carefully ascertaining that no pregnancy exists. Some years ago a case of hemorrhage, apparently clearly due to the menopause, came under my care. I treated her medicinally, as no examination seemed called for. She was better at first, but soon relapsed. I went away for my holiday, leaving her under the care of a medical friend. He declared no medicine did her good but *sabina*, which he thought was very successful; but the hemorrhage continued freely at the catamenia, with almost every other climacteric trouble. I examined her on my return, and found a polypus protruding from the os uteri. This I removed, and the hemor-

rhage, which considered as due to her age might have persisted for months, sank at once to insignificant proportions.

Again, a lady, weeks after the birth of a child, got recurrent attacks of bleeding, weakness, back-ache, and pain. She sent for me, and I at first thought that sub-involution accounted for her symptoms. Another doctor had confined her. The blood persisting, I examined and found an extensive fresh tear through the cervix. This caused me to place more dependence on copious hamamelis and calendula injections than upon *secale* or *sabina*, etc., internally, and shortly she began to gain ground and hold it.

But I have no wish to seem to underrate the value of internal remedies. In many cases they are all we have to depend upon, and it is surprising what these small doses will accomplish. With some considerable doubt as to their probable efficacy in the case, I recently took charge of a large fibroid tumor of the womb. The lady, over 50, was blanched with the drain which was kept up by the great myomatous mass, which protruded quite up into the right iliac fossa. I put her on *china* 2x and *secale* 3x alternately every three hours, and did little else except strictly to enjoin rest in bed during the early days of each "period." But in four months the change for the better was marked enough. The "periods" have been but half the length of what they had got to before commencing the treatment, and the healthier complexion and ability for walking, etc., testify to the gratifying improvement in the general health.

A vicious pathological circle is kept up in certain cases of sub-involution that we meet with. A weakly woman of feeble muscular fiber fails to get proper atrophy of the womb after confinement. The organ remains large, heavy, and congested. The lochia remains colored too long, and eventually apparently run into the menses, which last too profuse and with every degree of irregularity. An anæmic condition of the system is induced. Then the poor and

watery blood, with its diminished coagulating power, in its turn helps to keep the hemorrhage going. So the hemorrhage causes the anæmia, and the anæmia keeps up the hemorrhage until the unfortunate patient is reduced to a pitiable condition. Now iron, which should be the remedy for this state of things, is unfortunately often not well borne. I found in such a case lately that 5 grains of 1st trit. ferri et quin. citr. seemed (as iron in any form had always done before) to induce diarrhœa. In another case possibly a co-existing constipation is further increased.

Then recently in a case of chronic sub-involution, occurring in a lady of great delicacy of fibre with persistent profuse hemorrhage, I saw the muriate of hydrastis in 5 grain doses of 1st trit., as recently recommended from America, effect decided improvement, bracing up the nerves and delaying the menses. In another case, cimicifuga has been equally useful both for the main trouble and its various secondary consequences.

Cases of missed abortion are often very insidious, and we may easily mistake them for and treat them as instances of so-called functional metrorrhagia. An examination is all important here for the sake of one's own reputation and for the patient's safety. Fortunately, the indicated homœopathic remedy, such as sabina, secale, trillium or viburnum, often wonderfully succeeds in stimulating the uterus to the necessary contraction and expulsion, but we ought to know with what we have to do, and in no class of case can we so completely gain the patient's confidence as in this, when she sees that we fully comprehend her condition, which, by the way, she has frequently a perfect knowledge of herself, but has abstained from communicating to us. Frequently, as I have treated these cases, I have in almost all instances had the satisfaction, after making my diagnosis, of standing by and seeing the chosen remedy safely accomplish for me all I wanted without operative (which means for the patient dangerous) interference.

And how superior this is to the clumsy and hazardous, though occasionally necessary efforts of the operator, all must acknowledge who have ever had themselves to extract a retained putrid ovum probably with symptoms of commencing septicæmia setting in.

The hemorrhages of cancer of the uterus are generally easily distinguished; the peculiar fetor of the discharge and the sensation to the examining finger being too obvious to be mistaken. Injections of soluble phenyle—a non-poisonous preparation—is a wonderful comfort here both to the poor patient and her friends. I have seen of internal remedies *secale*, *hamamelis* and *crocus* effect considerable decrease in the hemorrhage. As a general rule, in all hemorrhages I prefer the use of hot to cold injections in acute cases and when pain accompanies, as in the debilitated. They have a much more reviving and stimulating effect, and by this means will check bleeding when cold water will fail.

Severe cases of simple functional climacteric metrorrhagia are met with. They should be subjected to examination if possible, for other causes may co-exist as in the polypus case related. Failing this they should be treated on the usual principles and by the remedies above named for uterine hemorrhage.

POST-DIPHTHERITIC PARALYSIS, ITS PATHOLOGY, ETIOLOGY, AND DIAGNOSIS.

BY WM. OWENS, M.D., CINCINNATI, OHIO.

Post-diphtheritic paralysis is a sequela of diphtheria, and is no more an essential part of that process than is pyæmia an essential part of a surgical operation. It must, therefore, be regarded as an accidental condition and secondary to gangrene, crampous diphtheria, or septicæmia. It arises from anatomico-pathological lesions attending some of these conditions in which capillary hemorrhage, apo-

plexies, or infiltration are present, interfering with or destroying the functions of the nerves which supply the parts affected. Cœrtel states that numerous and large apoplectic infiltrations and deposits are found within the cranium in the dura-mater and in the pia-mater far down into the sulci, and that they have been observed in the medullary substance and in the commissures, in the optic-thalami, the striated bodies, the crura, the pons, and in the choroid plexuses of the ventricles. They have been traced along the medulla oblongata to the spinal cord, and along the spinal cord into the intervertebral ganglia and roots of the spinal nerves and the connective tissue envelopments. The spinal nerves and their sheaths become infiltrated and swollen to nearly twice their usual size. This swelling and thickening of the nerves and their sheaths greatly interferes with the functions of these nerves, and is the cause of the muscular paralysis after diphtheria, which if long continued gives rise to atrophy and softening of the tissues. This condition may be removed in the course of time by judicious management. The capillary hemorrhages and infiltration taking place at the base of the brain presses upon and interferes with the functions of the nerves which take their rise here, and causes paralysis of the muscles about the mouth and throat, and furnishes us with the earliest and most frequent indications of post-diphtheritic paralysis. The velum palate, uvulæ and vocal cords are usually the first to lose their sensibility and motivity; sometimes one side alone is affected, at other times both sides become involved. These conditions interfere with the functions of speech, vision, hearing, deglutition, and expectoration. The speech becomes thick, guttural, and inarticulate; liquid food persistently returns through the nose, while solid and liquid foods both have a tendency to fall into the relapsed and open glottis, and thus endanger life. Large quantities of mucus accumu-

late in the nasal and pharyngeal cavities, and are expelled with difficulty.

The hemorrhagic apoplexies and infiltration into the interstitial ganglia and their nerve proliferations in the lumbar region are found to be more extensive than in any other portion of the spinal tract, and as a consequence the lower extremities are second in point of time in loss of motion and sensation. This is manifest first by numbness with sensation of coldness in the toes and feet, followed by a feeling as if pins or needles were sticking in the parts. Sharp pains extend into the feet and ankles; the legs feel weak and exhausted; the patient loses control of himself and sinks down utterly helpless wherever he may be. The loss of sensation in the upper extremities usually comes later, and begins at the end of the fingers with tingling, numbness, and formication. The sensations are as if the parts were asleep. These conditions extend over the hands, arms, and shoulders; the patient soon loses control of the movements of his arms and hands, which lie in any position in which they may be placed. The loss of motion usually precedes the loss of sensation and is more complete. The neck and back undergo similar changes, showing that the cervical and dorsal regions are passing into a similar state, and that the intervertebral ganglia and nerve roots are becoming infiltrated and nerve functions arrested. The patient soon becomes unable to raise his head or change her position without assistance. The bladder, rectum, and diaphragm may become involved later; the muscles of the chest and heart fail to respond. Respiration and contractions of the heart become slower and slower, until paralysis of these parts becomes complete, when cyanosis and asphyxia close the scene.

Etiology of Post-diphtheritic Paralysis.—Assuming that our views of this condition are correct, we shall endeavor to point out what seems to be the causes which precede and attend this state. These are two-fold, predisposing

and active or immediate. The predisposing are two; first and most prominent, the diphtheritic process itself; and the second is diathesis or constitutional predisposition, or a tendency to a pyogenetic condition, and a great liability to become septicæmic from the slightest cause, persons who recover slowly from the acute disease, persons of low vitality and poor nutrition. The direct, active, or immediate cause of post-diphtheritic paralysis will no doubt be found in the secondary conditions of gangrene, capillary hemorrhages or septicæmia. *Gangrene* not only destroys the parts locally, but often involves nerve trunks, which for the time being, at least, causes paralysis of the parts supplied by these nerves. Capillary hemorrhages arrest the functions of the nerves of parts by infiltration and compressing them, while septicæmia brings about a similar result by inducing hematic changes, paralysis of the vaso-motor nerves and relaxation of the muscular walls, with transudation of serum, extravasation, infiltration, etc., giving rise to œdema and loss of power. Another and very frequent cause of post-diphtheritic paralysis will be found in the too common habit of removing the diphtheritic membrane by violence, by tearing it off, or burning it off with caustics, alcohol, astringents, and the like; nothing could be more pernicious than this, increasing the irritation and extending the inflammation without any corresponding benefit, for by whatever process the membrane is removed it soon is formed again, and usually extends over more surface than before. The second or third formations are always thicker and more dense than the former ones, and consequently more liable to induce secondary conditions. The ingestion of solid food is subject to the same objection. Attempts at deglutition of solid masses will cause an abrasion of the already diseased epithelium covering the false membrane, and thus expose it to the access of micrococci, which tend to develop putrefactive changes in it. The absorption of the putrefactive matter gives rise to blood-poisoning. As long as

the epithelium remains intact the micrococci can have no access to the diphtheritic membrane, and we shall have no decomposition of the membrane and no septicæmia. Putrefactive decomposition, absorption, and septicæmia are essential and successive steps in the production of post-diphtheritic paralysis. It is the rule that the more extensive and dense the false membrane of diphtheria, and the more violent the primary attack, and the more meddling in the management is indulged in, the greater will be the liability to post-diphtheritic sequelæ.

Diagnosis of Post-diphtheritic Paralysis.—The first question which presents itself in the diagnosis of this condition is this: Has the party sustained recently an acute attack of diphtheria? Second, if so, what were the method and means used in treating it? and third, what were the sequelæ, if any? and was there local infiltration, gangrene, croup, or septicæmia? These questions answered, we are prepared to consider the significance of the phenomena attending post-diphtheritic paralysis.

The first and perhaps the most important symptom which will arrest our attention, is the secondary fever which usually sets in between the fourth and eighth days after the primary attack. This may occur though the pseudo membrane in the throat, nose, or other mucous surfaces, has not wholly disappeared. The appearance of secondary fever at this time will be a very constant indication that further trouble may be impending. The temperature may increase from three to four degrees, and is quite persistent. The pulse becomes hard and cord-like, soon to be followed by apoplectic hemorrhages within the cranium, infiltration into the ganglia, glands, connective tissue, and along the spinal cord; difficulty in hearing, speaking, and swallowing supervene, with loss of motion and sensation in the extremities. Should the paralysis progress further, complete loss of power over the voluntary muscular system comes on, invading one group of muscles after another, until in many

cases the patient becomes utterly helpless, and yet some of these extreme cases do recover and after a few months are as well as ever. A differential diagnosis is not difficult in post-diphtheritic paralysis.

A CASE OF CHRONIC INVERSION OF THE UTERUS.

BY N. W. VANDENBURG, A.M., M.D., FORT EDWARD, N. Y.

January 10, 1889, I was called in the evening to see Mrs. G., married, age sixty-three, medium height, rather stout, an active, industrious housewife. She is the mother of two grown-up children, and the youngest, a daughter, is eighteen years old. Since the birth of this daughter the mother has not been well. At the time of the last confinement, Mrs. G. was forty-five, and since then has had no regular menstrual periods, so far as she can now remember. There was subsequent to this confinement considerable dragging and bearing-down feeling, which culminated seven or eight years ago in the appearance in the lower part of the vagina of a tumor of some sort, that gradually settled down until it protruded beyond the vulva.

For the past seven years, as nearly as she can remember, it has been constantly exposed between the thighs.

At first moist, tender, and liable to bleed, with blood-vessels exposed and liable to rupture, it has within the past three years assumed a state of much greater toleration; the surface becoming more firm, and finally dry and leathery like the superficial skin of the body. The surface was, however, liable to be abraded by the attrition of the clothing, although she constantly wore a bandage or support of some sort.

I had treated this lady for other difficulties than this, more or less for the last four or five years. She had occasionally hinted at this trouble, but met all my suggestions

for a physical examination with an excuse for delay, so that I was utterly in the dark as to the cause, and had almost forgotten that the subject had ever been mentioned.

When called at the above date I found her in bed, suffering from dragging pains in the lower part of the body, especially in the left side. Sometimes the pains were quite severe for a time, then they would ease a little to return again.

She said on my arrival she was not so bad as she had been two hours previous. I did not consult my repertory nor my satchel of books, to find the similimum, nor did I think a "vaginal examination was something worse than useless."

In short, from former experience, I thought it more useful than anything else, and called for "the usual basin of warm water, soap, and towels." I expected to find a prolapsed uterus, though I hardly expect such a thing under ordinary circumstances in a woman past sixty years. But the "symptoms as a totality" showed something of this sort was the cause.

Making the digital examination wholly without exposure, I was completely nonplused to find, after repeated trials, that I could not find a vagina. I found a small orifice like the meatus urinarius, but absolutely no passage beside this.

Instead of telling me what I had forgotten in her case that there was a tumor without the body, my patient submitted with protestations that she thought the examination could do her no good.

At a loss what to do next, I was withdrawing my hand when the back brushed against a large tumor between the thighs and lying closely against the farther leg. This tumor was as large as a good-sized coffee-cup, elongated, pedicled by a thick soft base. The feel at once disclosed the fact that it contained intestinal folds. Gentle taxis, in the course of five minutes, greatly reduced the size, and the fingers seemed to follow an intestinal sinus upward into the body. After this occurred, all pain and dragging

ceased, the patient declaring that she felt all right. But said I, "What is this?" "Oh, you can not do any good to that, it is always there." Feeling about the base, no vaginal passage could be found, but the neck of a continuous sack, that sprung from between the labia and terminated in the leathery tumor. The outside skin moved freely over the inner mass. There was within, apparently to the distance of half an inch, a more firm but not a hard pear-shaped body, one inch by two or three long.

On the next day I called again, but the bowels still feeling slightly tender I waited until the next day.

On the third day from the reduction of the intestinal hernia, with the hand well softened in warm water, and well smeared with the best glycerine soap, in the course of ten or fifteen minutes the whole tumor was not only reduced, but the fundus had been followed up with the finger-tips and the hand passed within the body and pushed up as far as the wrist.

Pleggets of antiseptic wool saturated with 5 per cent. alcohol in water, and 1 per cent. of *ustilago maidis* tinct., kept things in place for the next twenty-four hours. These were then removed, and a thorough irrigation with warm water used.

For the next twenty-four hours no pleggets, but irrigation three times. The third twenty-four hours pleggets as before, though less in number. The vagina was plainly furrowed longitudinally at the end of the first twenty-four hours. At the end of the second (without tampons), it was furrowed still deeper, and the number of ridges increased. The third twenty-four my patient was out of bed for most of the day and very comfortable. The fundus, nor any part of it, could not be felt per vaginam. The surface was moist and normal in feel but for the ridges and the thickening. After the first day no unpleasant odor. No rise of temperature, no pain at any time.

After five days the patient was able to sit up and walk

about with more ease than for years. Precaution is still taken to keep a plegget or two of wool in the vagina, passed well up with Dr. Grant's placenta forceps, the most complete thing I know of for working high up in the vagina. They are absolutely free from the slightest chance to grasp any of the parts in opening or closing the blades. I expect nature to do much for this woman, in that the uterus is long past the active period, and has developed such a degree of toleration that it offers no chance of danger that I can see. Should it shrink as I hope on return of normal circulation, I see no reason why, at seventy, this woman should not be in better health than at fifty.

This is the most tolerant case of inversion that I remember to have learned anything about. The hernial complication seemed to have been brought on by reaching up to hang clothes on a line, and was scarcely less remarkable for its toleration of management.

THE INSANITY OF PREGNANCY.

BY H. H. CRIPPEN, M.D., SAN DIEGO, CAL.

(Continued from page 40.)

DIAGNOSIS.—COMPLICATIONS.—PROGNOSIS.—It is unnecessary to speak of the diagnosis of the insanity of pregnancy or of child-bed, except that it is essential to differentiate acute puerperal mania from the so-called puerperal phrenitis and from the delirium of puerperal fever.

The early authorities appear to have regarded puerperal phrenitis as a species of puerperal mania; for Dr. William Hunter, in the manuscript copies of his lectures, says: "Mania is not an uncommon appearance in the course of the month, but of that species from which they generally recover. *When out of their senses, attended with fever like paraphrenitis, they will in all probability die*, but when without fever it is not fatal, though it (the fever) generally takes

place before they get well." Gooch,* following after Hunter, formulates the following: "That there are two forms of puerperal mania, the one attended by fever, or at least the most important part of it, a rapid pulse; the other accompanied by a very moderate disturbance of the circulation; that the latter cases, which are by far the most numerous, recover, that the former generally die."

At present, with a more exact knowledge of mental disease, we distinguish puerperal meningitis as a distinct disorder, that may be differentiated from acute mania by the contracted pupils, the intense headache, the high temperature, and the rapid progress of the disease toward collapse.† On the contrary, in acute puerperal mania, the pupils are usually dilated, the headache is not a prominent symptom, and the temperature seldom reaches a high degree except when complications are present. The premonitory symptoms of acute mania are also distinctive and have existed for a longer time preceding the marked onset of the disease. Some singular change of manner or mode of thought, or querulousness with incoherent talking, commonly appears before the violence of the attack.

Complications.—In speaking of complications we find puerperal fever the most dangerous, and that to this cause more deaths during puerperal insanity are due, than to acute mania. Other complications are frequent: an insane finger (a species of whitlow), abscesses, eczema, or, as is frequently the case, some lung trouble. My experience has been fortunate in the absence of septicæmia, but in the history of twenty cases reported by Dr. Campbell Clark, of Edinburgh, there were four cases of septicæmia, two of pelvic inflammation, and two of acute phthisis. Since these twenty cases were not

* "An Account of Some of the Most Important Diseases peculiar to Women," Gooch, 1831, p. 118.

† Of 16,444 cases delivered at the Dublin lying-in hospital, three only are reported by Dr. Collins to have died of phrenitis.—(Reid.) Bucknill and Tuke, *op. cit.*, p. 239.

selected cases, but those of a year's collection, it is but fair to believe that septicæmia in puerperal insanity is the cause of death in more instances than commonly supposed.

From the frequency of complications a hint may be derived as to treatment, and that is, do not allow yourself to become so absorbed in the psychic aspect of the disease as to forget the necessity of watching for local conditions.

Prognosis.—It appears to me that before so much attention was paid to puerperal fever and to puerperal septicæmia, many cases of puerperal mania must have had these conditions as complications. Certain it is that the death-rate was greater than it is at the present day. Under Esquirol, in La Salpêtrière, out of ninety-two cases, six died, or one in fifteen. Of Dr. Burrows's fifty-seven cases, ten died, or one in six.* Of Leidesdorff's twenty cases, one died. Webster saw five deaths in one hundred and eleven cases. Among fifty-eight cases in my own experience one died.

Besides prognosis as to life, we have the question of recovery of the mental faculties. Generally it is believed that the termination is favorable, and this is borne out by statistics. I append a table showing the duration and the termination of all my cases :

CURED.		pr. ct.
In 2 months.....	1	= 1.7
" 3 "	6	= 10.4
" 4 "	4	= 6.9
" 5 "	7	= 12.1
" 6 "	8	= 13.8
" 7 "	9	= 15.9
" 8 "	3	= 5.1
" 9 "	3	= 5.1
" 10 "	4	= 6.9
" 11 "	0	=
" 12 "	2	= 3.5
From 12 to 18 months.....	3	= 5.1
Total cured.....		50=86.2

* "Commentaries on Insanity."

DISCHARGED UNCURED.

	pr. ct.
In 10 months.....	1= 1.7
" 11 "	1= 1.7
" 12 "	4= 6.9
" 24 "	1= 1.7
<hr/>	
Total uncured.....	7=12.1

DIED.

	pr. ct.
In 2 months.....	1= 1.7

Such a tabular analysis must necessarily be affected by the fact that the Bethlehem Royal Hospital being in the nature of something a grade better than an asylum, the cases were from the middle classes of England, and also that better advantage for treatment were at hand than in the ordinary asylum. Still I find others placing the proportion of curable cases at 75 per cent., so that, taking the favorable circumstances into consideration, 86 per cent. is a fair rate.

Among the statistics of others, the larger number of cases will be found restored to reason within a year. Dr. Webster states as the result of his observation that, "three in every five cases of puerperal insanity may be confidently expected to recover within a year." Two-thirds of Esquirol's cases were cured within the first six months after the commencement of the attack. Of Dr. Palmer's nineteen cases, fourteen had recovered after four months' treatment, and two were convalescent. Of the thirty-five cases recovering under Dr. Burrows's observation, nine recovered in the first month, five recovered in the second month, five in the third, three in the fourth, two in the fifth, four in the sixth, one in the seventh, two in the eighth, one in the ninth, one in the twelfth, one in the fourteenth, and one in the twenty-fourth month. Dr. Burrows, continuing, says that one recovered after three years, two after four years, one after six years, and one after seven years, and that he never met

with one permanently fatuous from insanity. At the time of my attendance at the Bethlehem Hospital I had the opportunity, however, of observing the case of a woman who suffered from insanity following child-birth, and who, although a useful drudge, had become, after many years, stout and weak-minded, and untrustworthy when portable property was concerned.

In making up one's prognosis it is well to bear in mind the brief aphorism of Gooch, which still holds good after more than half a century has elapsed. Briefly stated, this is, that acute mania is a less durable disease than melancholia; it is more dangerous to life, but less dangerous to reason.

Septicæmia and its dangers have already been touched upon; it remains but to say that insanity may follow upon puerperal fever as after any other acute exhausting disease, and that the termination depends much upon the condition of debility. Suicidal tendency, too, is dangerous to life, more especially where morbid impulses exist, than where there are delusions prompting the patient to destroy her life. To sum up, then, the prognosis with regard to life depends chiefly upon complications, and if death occurs it is more often from secondary causes:

With regard to the restoration of the mental balance, melancholia has been spoken of as dangerous in proportion as it is prolonged. Such cases often become lazy, stupid in fact, lack will-power, and will pass into a demented condition unless aroused from their indifference. Probably the danger is greatest in those late in life, toward the climacteric. Rarely a case ends in general paralysis of the insane; more cases of general paresis occur among the unmarried women.

In all forms of insanity there exists a tendency to future attacks after recovery, and we have this well marked in the conditions under consideration. As already indicated, this tendency must be given due weight in prognosis, and especially must it receive careful thought if there is a family

history of neuropathies. But a previous attack does not necessarily imply that the next pregnancy will be followed by an upset of the mental balance; cases are cited in which the first attack was before marriage and the next not until after the eighth child, and, again, where patients have suffered after the first and third, third and fifth, or fourth and sixth pregnancy.

GYNÆCOLOGICAL RÉSUMÉ.

BY MARY A. BRINKMAN, M.D., NEW YORK.

The indications for Alexander's operation are far from being definitely settled. Some claim to be convinced of its utility, but there is much adverse criticism from high authorities in gynæcological literature. There have been reported about three hundred cases. In a recent discussion on the subject, Ch. Gyn. Soc., Dr. Jaggard said he was reminded of Billroth's remarks on the unjustifiable frequency of excision of the pylorus for cancer. After he had determined for himself the feasibility of the operation he waited four years before he saw a case that indicated the procedure. Within six months of the publication of this case, the operation had been performed some half-score of times by minor surgeons. There are many objections to Alexander's operation. Apart from the first, has it a legitimate place in surgery on scientific grounds, the difficulty of finding the ligaments prevents it from becoming popular, as Dr. Mundé expresses it. M. has largely overcome this difficulty by following less closely the minute directions of the inventor (JOUR. OBS., Nov., 1888). He maps out the pubic spine with the index finger of the left hand, making a dent in the skin by pressure to mark the position. Holding the part with the middle finger and thumb, a quick incision is made one and a half to two inches long down to the spine. The transverse fibers of the external ring are slightly nicked by this deep incision, through which "pops a little knuckle of fat." This indicates the terminal fibers of the ligament. The pillars of the ring are laid bare by scraping with the handle of the scalpel. An aneurism needle is passed under the fat and connective tissue lying in the ring, taking care to leave none of the fat as the ligament might be in it. By traction on the mass the fibers will be seen to extend between the pillars of the ring. The areolar attachment is loosened by scalpel handle or finger, when the cord will be plainly seen. Among the objections and drawbacks to

the operation we find that much traction is frequently required to draw out the ligaments, and they sometimes break. Their thickness varies even in the same woman; they may be no larger than a knitting-needle or they may be atrophied or adhered. No positive evidence of these conditions can be given in advance. If these atrophied ligaments stretch sufficiently they will not support the organ. Inguinal hernia may form sooner or later, instances of which have been noted. The forced anteversion of the uterus often causes inability to hold the urine as long as formerly. The ligaments may be absent. There is danger of peritonitis as a result of opening Nück's canal. The insufficiency of the operation as regards complications of uterine structure and adnexa, and the generally accepted position that adhesions of the uterus forbid the operation, all show that the field for this procedure must be very limited. One writer tells us that he is convinced of the advisability of using all auxiliary therapeutic measures preparatory to shortening the round ligaments. These he defined as repairing the cervix and perineum, anterior and posterior colporrhaphy, scraping and curetting the uterus, etc. Another says that it is assumed that, before operating, any constitutional fault will receive careful attention: pelvic congestion, sub involution, endometritis, constipation, etc., will be removed. The records of cases give us the impression that the haste to present a "series" of the Alexander operation has often outstripped the wisdom of the surgeon in the selection of the proper subject for the experiment. We are told that after-treatment (mechanical appliances) will be necessary for months, in some cases a year. The test of pregnancy with delivery at term has yet to be met. A few cases have been noted. We observe that Polk denies having combined hysterorrhaphy with Alexander's operation as reported of him, which Sängér justly criticised as "too much operative treatment." With all the "operative frenzy" of the times it is a good sign that there are those who feel that the "line must be drawn somewhere." We know that uterine displacements are, after all, but symptoms of a cause, as are relaxed or atrophied ligaments. In view of the serious drawbacks to the operation, and the probability of a return of the original displacement or of descent in the pelvis from some of the many causes which give rise to pelvic congestions or to structural weakness, it is safe to assume that but few cases will be permanently benefited by Alexander's operation. When we consider strictly those cases for which this operation was first proposed, and exclude from this class all that may be cured by proper hygienic and constitutional measures, combined with homœopathic therapeutics, the conscientious surgeon will rarely resort to this method of relieving uterine displacements. Hysterorrhaphy, which was first done to elevate and

fix the uterus after the removal of the appendages, and for which there seems ample justification, is now looming upon the surgical horizon as a primary operation. While in Alexander's operation the "suitable" cases are said to be those where the uterus is "freely movable and non-adherent," the indications for hysteror-rhaphy are "adhesions and fixation."

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Since December, 1887, Lee (JOUR. OBST., Dec., 1888) has considered it necessary to perform this operation six times.—Case I.: Age 36, married fifteen years, multipara. Laceration of perineum, cervix slightly torn, rectocele: retroflexion with firm adhesions. Symptoms, backache, tenesmus, dysurea, dysmenorrhœa. Two months treatment failed to break up the adhesions. Hysteror-rhaphy was performed Feb. 22, 1888. Patient discharged cured May 23. Patient was under observation six months and continued well. Case II.: age 30, married eight years, primipara. Old salpingitis, recurrent ovaritis, retroflexion, perimetric adhesions, dysmenorrhœa. Bedridden. Operation March 29, 1888. Appendages showed little evidence of structural change. "I should have left them had not the patient begged that they might be removed to force her menopause." Case III.: age 24, multipara. Retroflexion, fixation of uterus, prolapse of both ovaries. Dysmenorrhœa, dysurea, constipation, hysteria. Abdominal walls tense and muscular. Laparotomy May 17. Uterus could not be brought into abdominal wound; only one broad ligament could be sutured. Patient discharged June 15. She has relapsed; the uterus is dragged laterally. Case IV.: aged 29, multipara. Retroflexion with fixation, adhesions; perineum and cervix slightly torn. Prolapse of tubes and ovaries. Operation, June 4. Patient discharged June 30. Uterus in position and patient well six months later. Case V.: age 37, married eleven years, primipara. Perineum slightly torn, cervix nodular and tender. Retroflexion, adhesions. Hysteror-rhaphy June 26. Patient seemed well four weeks later. Case VI.: Single, age 27. Dysmenorrhœa, menorrhagia, retroversion, and prolapsed appendages, ovaritis. She entered the hospital Sept. 20, 1886. "As a last resort I determined to remove the appendages, Nov. 11, 1886." She continued to menstruate regularly and profusely, although both tubes and ovaries had been completely excised. The summer following the operation she had an attack of perimetritis, which left the uterus retroflexed and almost immovable. Hysteror-rhaphy was done Oct. 4, 1888. The case is reported Oct. 25, 1888.

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Abstracts from a paper on "Inflammatory Troubles of

the Uterine Appendages," (M. Harting) *Arch. of Gyn.*, Feb. 1889, abound in useful hints. Modern tendencies to rely upon objective phenomena for diagnosis induces many to proceed too hastily to local examinations. The history is frequently sufficient to establish the diagnosis. A girl who has every time violently painful menstruation, but who never had a feverish seizure with it forcing her to bed for a week or more, or who never had a violent accident, has no inflammation in the appendages; on the other hand a girl with intensely yellowish green leucorrhœa, perhaps painful urination, menstruation hitherto painless, who later is attacked during a menstrual period with violent colics and high fever or steady pain on right or left side, has chronic inflammation of the appendages. Acute inflammation, if it be the first attack, is difficult to recognize by the history alone. We receive the impression of peritonitis, which indeed is always present in more or less degree. The intensity of the pain prevents a thorough examination. It may be days before the case becomes clear. The prognosis will vary with the form of the affection. In acute cases it should be made on the first day, or at least just the minute we can exclude perforation ileus, and the spread of peritonitis to the upper part of the abdomen. Assuming that a morphine injection will be given, if the dose does not exceed $\frac{1}{4}$ of a grain, if the respiration becomes again abdominal the peritoneal symptoms will soon localize near the pelvis, and the immediate danger to life is over, even if a tubo-ovarian pregnancy should have come to bursting. If intense vomiting persists, the probability of the peritonitis generalizing itself is greater, especially when with cold sweat a thready and very rapid pulse exists. If the affection is localized from the beginning the prognosis is more favorable. A violent chill of half an hour, or if the chill repeats itself, should put us on our guard, even if the pain is localized and the peritonitis indistinct. This may indicate general septicæmia, thrombosis of veins, eventually endocarditis ulcerosa, while the inflammation of the appendages is of secondary importance, especially if we find no adequate cause for the repeated chill, as abscess. H—— concludes that there are two forms of inflammation of the appendages, one tending to chronic thickening of the tissues and adhesions, another leading to the formation of pus, this latter form leaving, after the pus has disappeared, residues resembling the first. The records of dissections would show the first to be a more common form, but we must remember that the history of those who are dissected is meagre, while it is wonderful how much inflammatory product can be absorbed in years. H—— believes time is the great element in dispersing these exudates, although tamponing, hot douches, poultices, warm, full salt and mud baths, iodides and general

tonics are hastening the process. The treatment of the acute case is that of peritonitis; the details may vary. H—— does not agree with Tait that salty aperients will carry off septic germs without perforation of the intestine. The plan may answer after ovariectomy at the first suspicious symptom. Saline aperients in acute localized peritonitis he deems hazardous and likely to generalize a local peritonitis. Early evacuation to prevent too intimate adhesions and sequential ileus according to Traube, he deems reasonable and would use mild measures—a clysma first, oil or saline next. Calomel might be retained and cause salivation. We are glad to note the above. Surely light is dawning upon the minds of our brethren who advocate such free use of opiates in these serious affections. Opiates lock up the secretions, check persaltic action; the system labors not alone with the disease, but with normal and abnormal secretions which should be carried off by the natural channels. H—— concludes that it is only possible to make a differential diagnosis as to locality, that is, tube, ligament, or ovary, and then only seldom without narcosis.

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It is desirable to determine between rupture of extra-uterine pregnancy and hematocele retro-uterine and peri-uterine. Here the history is most valuable. We can in the main distinguish two forms of chronic pelvic cellulitis—acute outbursts, and the more or less constant ailment most aggravated at the menstrual period. The acute form requires the treatment of peritonitis; if abscess forms, its evacuation as early as possible, if it does not take place spontaneously. The chronic ailments from adhesion and matting together of the pelvic organs must be treated symptomatically. Poultices, iodine injections, methodical tampon pressure, massage by combined manipulation, prolonged warm baths, with salt, or iron, or mud, mineral and saline waters, and all means of increasing tissue changes are useful. Attention to the digestive functions is valuable, as deposits of fat give the uterus elastic support, as does a well-fitting abdominal belt. Intra-uterine maneuvers must be executed with care and strictest antisepsis, or a fresh flame may break out. Intra-uterine maneuvers alone have often enough produced pelvic peritonitis as a primary cause. The same reasoning applies to replacing deviations in a patient who has had pelvic peritonitis. Anodynes should be used guardedly; abstained from altogether when possible. Nothing can occur more readily than the creation of the morphine habit in these cases. No anodyne should be used steadily. The rectal suppository is preferable to the vaginal. Very bad cases may demand removal of appendages; the worst, a total matting together of all the contents of the pelvis, would

die from the operation. A probatory incision will reveal the hopeless condition, and modern antiseptics makes the probatory incision well-nigh secure.

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At the gynæcological clinic at Vienna the methods of securing antiseptics consist of keeping the instruments to be used in trays containing thymol solution, 1-1000. Towels used are wrung out of hot antiseptic water. Irrigations of corrosive sublimate 1-5000 colored with pot. permang. are used. The hands of operators and assistants are scrubbed with soap, rinsed, then bathed in 60 per cent. alcohol, and then re-rinsed. Special aprons made of oiled silk regularly scrubbed and made antiseptic are worn. Beneath the aprons are linen dusters which are never taken outside the operating room. In his laparotomies Braun uses silk sutures throughout, cuts them all off close to the knots, and stitches up the peritoneum and abdomen tightly, leaving no opening for drainage. As a rule, he does not wash out the cavity with antiseptic fluid, uses no sponges, but depends on carbolyzed absorbent cotton. Previous to the operation the abdomen is well soaked, scrubbed, rinsed, and then rubbed with turpentine; then towels wrung out of bichloride solution 1-5000 are laid upon the part.—(G. C. Simmons, *Occidental Med. Times*).

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Lawson Tait thinks that amputation of the pregnant uterus, in cases where it is impossible to remove the child by the natural passages, will in a few years revolutionize the obstetric art.—(*Brit. Med. Jour.*) He has performed Cæsarian section three times, and the mother died in every case. In the fourth he removed the appendages to prevent further impregnation, but the patient died. He attributed these deaths to the "puerperal condition," which he now thinks is nonsense, as he has done four operations on the principles laid down by "Porro," and all the mothers have recovered and the children have lived. The details of Porro's operation have been changed, but the principle remains. Tait says it is the easiest operation in abdominal surgery, and every country practitioner ought to be able and always prepared to perform it. A knife, artery forceps, a piece of rubber drainage tube, two or three knitting-needles, and a little perchloride of iron are all the instruments that are required. An incision is made in the middle line large enough to admit the hand. The drainage tube as a loop is passed over the fundus uteri, and made to encircle the cervix, taking care that it does not include a loop of intestine. A single hitch is made to draw it tight around the cervix so as to completely stop the circulation. The ends are

held by an assistant ready for further constriction if necessary. A small opening is made in the uterus, and enlarged by tearing with the fingers, the child seized by a foot and removed. The placenta is removed, and by that time the uterus has contracted and is easily drawn through the wound in the abdominal wall. The tube will now require to be tightened, and another hitch to the knot put on, and the work is practically done. Sponges are stuffed into the wound to keep the cavity clear of blood. The knitting-needles are passed through the flattened tube and through the cervix, and in this simple way an efficient clamp is made. The uterus is removed about three-quarters of an inch above the rubber tube. The wound is closed around the stump, which is brought to the lower part of the opening. The stump is dressed with the perchloride of iron in the usual way. If performed before the patient has been injured by ineffectual attempts to deliver, Tait believes the mortality will be no greater than that of ovariectomy. He argues in its favor that it can be no more dangerous to the mother than other methods, it saves the life of the child, it prevents the mother from again being placed in a similar position, and it has the advantage of simplicity. Tait believes that this will be the operation of emergency when only the resources of general practice are at hand.

TRANSLATIONS.

SIXTY TOTAL EXTIRPATIONS OF THE UTERUS, SUFFERING FROM CARCINOMA.

BY PROF. FRITSCH.

(Translated for the *HOM. JOUR. OF OBSTETRICS* by S. LILIENTHAL, M.D.)

Seven fatal cases in sixty total extirpations, performed since 1883, are certainly such a favorable result that the prognosis may be considered a favorable one, when we look to it whether no relapse took place after more or less time. Of the fifty-three women on whom the professor operated so successfully, two have passed their third year, seven their second year, eight over one year, and three already over ten months. For the remaining the time is yet too short, and the conclusion may be offered that after the total extirpation of the carcinomatous uterus, relapses are more rarely met than in any other carcinoma.

Fritsch opposes Kuge's strict differentiation of portio-carcinoma in carcinoma of the portio and of the cervix, as in both relapses

are frequent and the total extirpation offers better chances of recovery, especially as Zinswanger's case showed that besides the cancer in the portio vaginalis there may be also carcinomatous nodes in the fundus, and a primary amputation renders at a later period total extirpation far more difficult. The latter is also more easily performed, and with less loss of blood, than the former. Only in totally isolated, early detected, small nodules he advises the high amputation.

Movability of the uterus, when the drawing downwards is more prevented by parametral than by peritoneal fixation, is the chief indication for total extirpation; of less importance is the size of the carcinoma and the feeling of other tumors next to the uterus. He prefers to make the first incision laterally, to finish the most difficult part of the operation, which is to take care of the parametria, and his last step is the opening of the peritoneum, which ought to be limited to the smallest space possible. He leaves open the hole left by the operation—iodoform tampons—no irrigations. The earlier the operation is performed, the more hopeful the prognosis.—*Vienna Med. Presse*, 5, 1889.

TREATMENT OF VESICO-VAGINAL FISTULA BY THE REMOVAL OF ALL CICATRICAL TISSUE.

Dr. G. Walcher teaches in the *Centralblatt f. Gynäcologie* that after the removal of all cicatricial tissue we often will feel astonished how the mobility of the fistula's edges increases, with what ease they approach each other without the least pulling. To render the vagina, the bladder, and the rectum mobile again, Walcher circumsised at first the border of the cicatrix at a place more remote from the field of operation, *e. g.*, at the side turned to the bladder, circumsises then the whole cicatrix in the vagina, and removes the cicatricial tissue from its whole depth. As long as there are yet any immobile parts, they must be thoroughly cut out. Finally the wall of the bladder becomes so mobile that it can be pulled out like a loose sac from the wound, and then linearly united with catgut. After closing the bladder, the wound in the vagina is closed with silk sutures by colporrhaphy. Thus a broad place of union is made, which on account of the slight tension heals kindly *per primam*.

—Dr. J. C. Da Costa prefers silk ligatures to any other form in operations upon lacerated cervix, as strong and never causing serious effects. In one case the suture accidentally remained six weeks without any evil results.

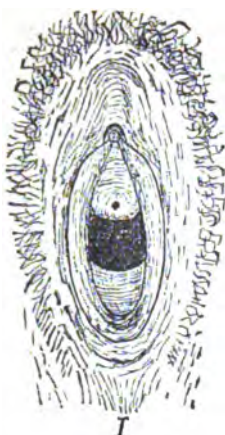
ABSTRACTS.

THE HYMEN.—E. S. McKEE, M.D., in *Annals of Gynecology*.—This organ, termed by the Latins *Membrana Virginitatis*; by the Greeks, a pellicle; among the Germans given the various terms, *Scheidenklappe*, *Jungfernschlösslein*, *Jungfernhauttschen*, *Jungfernschatz*. The French call it *Copule* or *Cypri*s, the latter term often found in *Fontaine*. *Chaperone* meant first a head-dress worn in France by doctors and bachelors of art until the reign of Charles VIII. Later it came to mean an old woman who watched young girls. Now it is becoming to have the significance, guardian of virginity.

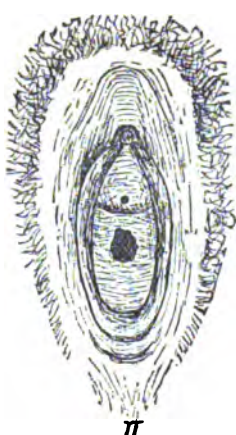
We find the following varieties :

- I. The hymen *semilunaris*, or normal hymen.
- II. The hymen *circularis*, with small central opening.
- III. The hymen *cribriformis*, sieve-like, containing many holes like a water-pot.
- IV. The hymen *fimbriatus*, similar to the fringe-like appendages of the *ostium abdominale* of the *tubæ Fallopianæ*. This form is the most important in a forensic point of view, as it may be taken for the normal hymen which has been torn.
- V. The hymen *imporforatus*. This is a frequent cause for surgical treatment, on account of the *retensio-mensium* dependent upon it. It may prevent copulation.
- VI. In rare instances the opening of the hymen is found divided into two parts by a perpendicular bridge from the concave border of the hymen to the *meatus urinarius*, where it becomes fast.
- VII. In some instances there is a variety in which there exists an upper or anterior and lower or posterior opening, with simply a band lying transversely across the vagina. In rare cases we also find a second hymen existing above the first.
- VIII. The horseshoe hymen.
- IX. The bi-lobate hymen.

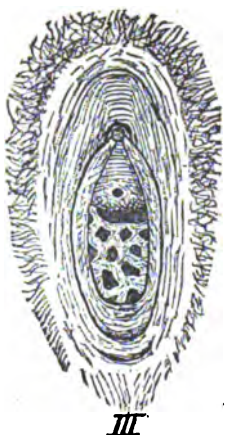
Atresia vagina membranacea seu externa is the term applied to the hymen *imporforatus*. In this we have a thickened, toughened state of the membrane. We should differentiate between *atresia interna* or complete, which either depends on an incomplete development of the vagina, or its entire absence, or a diseased condition of the same from ulcerative processes.



I



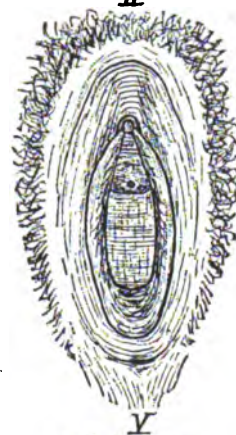
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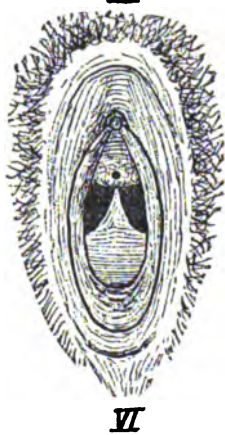
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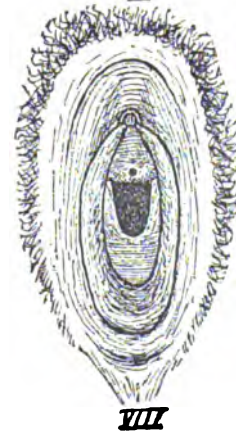
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VI



VII



VIII



IX

DeBeck

Fig. 9.

MINOR PARAGRAPHS.

—A characteristic sign of pneumonia in infants is a little moan with each expiration ; a little catch of the breath first, then the moan with the expiration.

—Antipyrine is contra-indicated in albuminuria and in all renal disease where there is a scanty excretion of urea, as it diminishes the quantity of urea in normal cases.

—Sometimes an infant's tongue can be exposed to view by simply pressing the cheeks gently with thumb and finger. If necessary, hold the nose for a moment and the tongue will come in sight.

—Always tie two ligatures on the umbilical cord, says Prof. Parvin. The ligature on the placental end prevents the placenta from becoming emptied of its blood, and thus promotes its separation.

—Geo. R. Southwick, M.D., Boston : There is no doubt that the use of carefully prepared catgut in the treatment of perineal laceration is meeting with much favor and not unlikely will supplant the older methods.

—Prof. Richardson : The morning sickness coming on in the latter months of pregnancy is seldom due to reflex action, but to direct pressure on the stomach and digestive tract, and this sickness is not cured, as a rule, till the child is born.

—The best drainage tubes are either red rubber or glass, according to Prof. Gross : make the rubber aseptic by scrubbing with soap and water, and keeping in 1 to 1000 corrosive solution; the glass by boiling for ten minutes in simple water.

—Lying with the shoulders low and the hips elevated will give quick relief from vomiting during pregnancy. A linen compress, saturated with French brandy, strapped tightly over the gastric region with adhesive plaster, acts mechanically in holding the muscles quiet, and will sometimes do wonders in these cases.

—The ligatures used in Jefferson Hospital are prepared by taking ordinary catgut, immersed in alcohol containing 1 per cent. corrosive sublimate and 5 per cent. tartaric acid for one hour. From this solution, immediately place in oil of juniper berries, where it must remain at least ten days before it is ready for use. When wanted for use, wipe the gut with a towel wrung out of a solution of bichloride of mercury, 1-1000, and place it in a similar solution, to which has been added 20 per cent. of alcohol ; the alcohol prevents untwisting and swelling.

THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

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A FEW THOUGHTS ON GYNÆCOLOGY IN THE LIGHT OF THE ORIFICIAL PHILOSOPHY.

BY E. H. PRATT, M.D., LL.D., CHICAGO.

With all due respect to the scholarly productions upon gynæcological subjects to be found in text-books and in medical journals, the principles of the orificial philosophy, as they become better understood, will have a tendency to check much poor work that is still being done in this important field of practice, and introduce somewhat of system and order into the confused and confusing teachings of the recognized gynæcological experts, and may possibly also suggest a few practical notions that have already been too long disregarded or not fully appreciated.

The statement that much poor work is still done in gynæcology will probably pass unchallenged. That present teachings are confused and confusing is shown by the way practices of various kinds are indorsed and then abandoned, and almost every measure, from the use of dilators and pessaries to their abandonment, has champions and foes who fill the air with the din of contention until it is difficult to decide who is the stronger in the conflict.

One figure, so prominent among us as to be denied the

restful blessedness of obscurity in whatever he does or says, has indulged through a long professional career in the practice of attacking the endometrium with tents, caustics, curettes, etc., and by his example and writings has persuaded thousands of his professional brethren to adopt his methods; and now, so late, when his life's work is almost done, and his army of followers are still looking to him for further guidance, gives the lie to his entire life and teachings by calmly coming to the conclusion that except for the removal of tumors and other vegetations, and of remnants of placenta, it is better to leave the uterine cavity unexplored, taking the ground that most uterine troubles have their origin outside and not within the uterus. If men are to be held responsible for the consequences of their mistakes, what an account this poor veteran will have to settle for his lifetime of bad practice—if his present conclusion is correct.

Whether the principles of official philosophy will help to guide the profession safely through this era of conflicting opinions and practices or not, time alone can tell; but at any rate a few remarks upon its application to gynecological practice will not be out of place, and may possibly be of use to some who are still undecided what to believe and what course to take.

First of all, the following proposition deserves candid consideration:

"Work upon the sexual system is ineffective and oftentimes harmful, if rectal irritation is present and allowed to continue uncorrected."

The proposition is sweeping, is not ambiguous, and is either true or false. If it is true, what has the medical conscience to say for itself for its past oversight? Think of the thousands of women who are periodically subjected to all sorts of so-called treatments for months, and even years, in succession, when possibly the good doctor is but dabbling with a reflected condition; and yet the source of the trouble has never been thought of, and much less examined. He

has appreciated a few reflexes, perhaps,—as, that uterine disorders may account for a stomach or heart or head trouble,—but has never waked up to the fact that a rectal disorder may possibly also produce reflexes, even upon an uterus.

If the proposition is not true, as soon as the writer can be satisfied of its falsity, he has an ample apology for ever suggesting it, at the disposal of the profession. Theorizing will not settle the question, but a careful investigation of individual cases will. Let those who have on hand cases of obstinate endometritis, congestion, leucorrhœa, dysmenorrhœa, etc., etc., institute an investigation, and then their reports will be valuable.

In the second place, "the irritation of an organ starts at its mouth." Applied to the female sexual system—an adhesion of the hood to the clitoris may explain sexual hyperæsthesia; an urethral caruncle may explain vesicle irritation—an irritable hymen may explain a vaginismus or a vaginitis; a diseased external os may explain a cervical endometritis; a faulty internal os may account for corporeal endometritis and other disorders of the body of the uterus; and an irritation of the endometrium at the uterine orifices of the fallopian tubes may account for numerous ovarian weaknesses.

If Batté would seriously consider this subject for a few months, might he not save a few ovaries that he would otherwise have deemed it essential to sacrifice? "All orifices should be dilatable, and free from all forms of irritation." All the lower orifices are guarded by sphincter muscles more or less supplied by the sympathetic nerve.

The fact that sympathetic nerve waste can go on painlessly from abnormal contractions of these muscular fibres kept up by very slight forms of irritation, needs more careful consideration than it has hitherto received. Have we not had our attention confined too much to effects and too little to causes? Do we sufficiently realize that the sexual system is supplied by the sympathetic nerve, and that upon the tonicity of that nerve depends our very life?

Every night, as we wander in dreamland, the lordly cerebro-spinal system lies down to repose with the rest of us, trusting to the tireless and uncomplaining sympathetic to keep the fires of life still burning. If she is strong, and does her work well, we awake refreshed, with every organ, even the tired brain itself, renewed for another period of activity ; but if she is weakened by excessive demands upon her, her work of repair is incomplete, and we emerge in the morning with lowered vitality and insufficient resisting power. Tight sphincters can accomplish this mischief, but it is useless to relax them unless the irritations that induced their tension be first removed. "Where there is a metastasis of irritation there is also a metastasis of congestion."

If in a case of local injury involving a terminal nerve of the cerebro-spinal system there be a metastasis of irritation to the other extremity of the nerve filaments, causing tetanus, convulsions, chorea, or other similar troubles, there will also occur a metastasis of congestion, and there will be small local evidence to account for such serious general mischief. The same holds good of the sympathetic system. Severe congestions, inflammations, and local disorders that are excessive and readily recognized, are chiefly a local inconvenience to the patient—the area of aches and pains and functional disturbance being quite limited.

Should the sympathetic nerve centers become involved by metastatic irritation, and the mischief transferred by other nerves issuing from them to a stomach, a lung, a heart, a brain, a spinal cord, or other remote organ, the congestion will also be transferred, and the signs of local mischief will disappear to a remarkable extent.

This simple trick of nature has misled many a good diagnostician in his efforts to unravel an obstinate case, and doomed him to ignominious failure.

In applying this knowledge to the cure of the chronically sick, the gynæcologist will find his field of labor much

enlarged, I am sorry to say ; although, as it makes his work applicable to more cases, the other principles of the philosophy will materially shorten his work upon individual cases, and thus so even up the account with humanity as to remove all cause for complaint on that score. This leads to the thought that although in a given case there may be no malposition of a uterus, no outward signs of local mischief, no erosion or leucorrhœa, or other of the annoying local symptoms (so common) of abnormal condition present, still, an atrophy of the uterus, or a stenosis, may give the key to remote complaints that have baffled all efforts at relief.

In applying the ordinary principles of free vent by thorough dilatation after the removal of all small points of irritation in such cases, you need not be surprised to find that while your handling has touched the right spot, *i.e.*, has removed the reflected disorder, it has also left, on your hands quite a severe local condition which did not before exist. If this philosophy is true, it is the very state of affairs to be expected, and, indeed, to be desired. Sometimes it will come at once ; oftener at a later period and by degrees. Its appearance ought to encourage both patient and doctor, for, whereas previously the entire system was involved, the trouble is now localized, and although it will be the last spot to get well, when it is well the case will be entirely recovered, reflexes and all. I say that formerly the whole system was involved, because a trouble could not start at a lower orifice, and by metastasis affect remote parts, without traversing and more or less affecting the intervening stretch of nervous connection. Such cases need handling with extreme care; and in doing so, the nearer we approach in our methods to the habits of nature, the more perfect will be our success. Nature renews and cures her women by the dilatation consequent upon child-bearing. It is rather a severe measure, and, to receive benefit from it, ought not to be indulged in too often—once in from two to

five years, according to the reactive power of the patient, usually suffices to maintain a woman in the most perfect of health—other things being equal.

If this extreme dilatation becomes too frequent, the poor victim has not been allowed sufficient time for recuperation and the enjoyment of the revivifying process, her uterus gets tired, her whole body and all its parts get tired, and if in this debilitated state no local spot in her system is weaker than the rest and gives way, she finally gets too tired to live and passes into her rest, although the cries of her needy children may spur her on to almost superhuman efforts to live for their sake.

Does not this suggest a possible mistake made by many of us who have felt that if there was trouble inside of the uterus, there ought to be some way of getting at it, and doing good instead of harm?

Have we sufficiently imitated nature in thoroughly cleansing out and in renovating the endometrium—in thoroughly dilating every part and particle of the uterine cavity, and then in thoroughly letting it alone for a protracted period?

Personally, this is a confession; and success is surer and more rapid as I do less work and do it more thoroughly, respecting always the principles that the lower orifices experience a mutual dependence, and to overlook one of them in the handling of any gynæcological case is to hazard success in the case.

Now, although the uterine cavity should not be frequently entered (except in those deep-seated reflected cases where it appears desirable to induce more or less local irritation) in cases where reactive power is poor and nutritive changes are sluggish, another principle of nerve distribution gives sanction to some of the measures now in use, only they should come after the proper internal work is done—not before it; and that is, that pencils of nerve filaments in close sympathy are distributed to the

various parts of an apparatus, so that one part can affect another.

In the first volume of Woods' Library this law of nerve distribution is clearly illustrated by Hilton, only he speaks of the cerebro-spinal instead of the sympathetic; but as the two systems operate on similar plans, the illustration is apropos in this connection. He says that "where a nerve goes to a joint surface, another branch of the nerve supplies the muscles that move the joint, and another branch of the same nerve goes to supply the skin surface over both muscles and joint." Hence, when a joint surface becomes inflamed, the muscles of the part suffer contraction, and the covering integument becomes hyperæsthetic.

But it is a poor rule that will not work both ways, and if a disturbed joint can communicate its distress to the skin and afford it discomfort, an outward application that has a tendency to allay the disturbed condition of the skin must be able, by means of the same set of nerves, to soothe to some extent, at least, the irritation of the joint itself.

Let us appreciate, then, if we can, that the pencil of sympathetic nerves which combines to carry on the functions of the sexual apparatus have an area of terminals as extensive as the mucous membranes, muscles, and glands involved, and that a morbid condition of any part of this apparatus can influence any or all other parts, and that by means of this same set of nerves soothing influences can travel also in the same direction.

Hence it is that, after thorough inter-uterine work has been accomplished, if reaction is at all tardy, and morbid conditions linger unduly, a proper use of local applications and appliances appropriate to the case will become of great assistance.

Of all the orifices involved in this work the internal os uteri is by far the most important, and the one which will most frequently require attention; but as it is not my intention in the present article to consider anything beyond the

merest outlines of a few general principles, I will leave to a subsequent composition the discussion of details of procedure.

One other point deserves mention in this connection, and I will illustrate it by the description of a single case: Mrs. C., aged fifty-five, although weighing about 175 pounds, had been confined to her bed for about nine months, suffering from severe choking spells, presumably due to the presence of an enormous goitre. Strange to say, the sitting posture so aggravated her condition that she was compelled to recline continually. She passed through the hands of several experts in nervous, throat, and surgical diseases, without relief. One of them was thoughtful enough to explore her rectum, but found it normal. The only hope which the lady derived from these various sources was the possibility of reducing the middle lobe of the thyroid gland by the daily use of electricity, it being supposed that this condition was the occasion of her choking spells, which were numerous and so severe as to endanger her life. Obtaining no relief from this and other measures tried, her case was abandoned, as it was deemed inadvisable to attempt the removal of the goitre, and she was about to be sent home as a hopeless case when, through the influence of a friend, she was induced to submit to another examination. After hearing her story and listening to the opinions that had been given in her case, I asked if any one of the doctors had examined the condition of her uterus. She said No; that she had never had any uterine trouble, and no one had thought it of sufficient importance to even suggest an examination; whereupon I remarked that if she had been twenty-five years old instead of fifty-five, probably every one of the medical gentlemen who had been called to her case would have considered it his duty to make a local examination, but because she was five years past the change of life and had presented no local symptoms, the doctors evidently forgot that she still had a uterus, and that it was

still capable of producing either local or reflex disturbance. Under an anæsthetic an entrance was effected into the uterine cavity, the cervix having been completely stenosed, so that the entrance was made with extreme difficulty. The cavity was filled with an accumulation of thick mucus. Thorough dilatation, swabbing, and douching were practiced, the bowel thoroughly dilated, and the patient returned to her room. She experienced immediate relief from her paroxysms of choking, and in two or three weeks was discharged, completely recovered. The point which this case illustrates is that the period of mischief from uterine derangements is not limited by the menopause, and the sufferings of elderly ladies frequently arise from uterine troubles which are overlooked. I have seen repeated instances of this in cases of asthma, dyspepsia, headaches, dropsy, paralysis, bronchitis, insanity, etc., and feel that many practitioners are in need of this suggestion.

This is but a very imperfect and partial consideration of this vast subject of terminal nerve irritation and its possible reflexes as developed by a study of official philosophy, but exhaustive writing is more appropriate in text-books than in journal communications.

ON PNEUMO-THORAX IN CHILDREN.

BY THOMAS NICHOL, M.D., LL.D., D.C.L., MONTREAL, CANADA.

I.

No mention is made of this morbid state, which is rather an accident than a distinct disease, in any of our systematic treatises, save that of Raue, who treats it with his usual clearness, while Meigs and Pepper are the only writers on the Diseases of Children who make any reference to it. A separate chapter on it seems to me to be desirable, not so much for the sake of completeness, as because there are cer-

tain peculiarities in this morbid state as it appears in infancy and childhood. It is, however, a comparatively rare disease in children.

Pneumo-thorax, then, is simply an accumulation of atmospheric air, seldom pure; in the pleural sac or sacs, resulting in compression of the lung, extreme dyspnœa with anxiety, and certain physical signs which are sufficiently obvious.

Strictly speaking, pneumo-thorax cannot be ranked as a disease, it is rather an accident, or rather incident, in the course of several very dissimilar morbid states. Dr. George Gregory gives the following account of its most usual origin: "A tubercle forms near the surface of the lung. In the process of ulceration, aided by the force of coughing, the pleuritic covering of the lung, if unsupported by adhesion, gives way at that part, and subsequently, at each successive inspiration, a portion of air escapes through the opening thus made into the general cavity of the chest. The result depends on the degree of adhesion which may previously have taken place between the two surfaces of the pleura. If the adhesions are firm and extensive, the rupture would either not take place, or would occasion no inconvenience. If the lung be entirely free, it is gradually compressed by the air thus escaping into the pleural sac, and respiration becomes hourly more and more laborious. If the accident happens on the left side, the heart may be pushed over toward the right."

Pneumo-thorax, then, is invariably a secondary affection, and it varies considerably with the nature of the primary disease. It is so very frequently an incident of pulmonary phthisis that we may almost say with Dr. Anstie, "The subject of pneumo-thorax, from the physician's standpoint, falls almost entirely under the domain of phthisis." There are two distinct forms of pneumo-thorax: First, that in which a perforation of the pulmonary pleura communicates with the air through the bronchial tubes; and, secondly, that in which the perforation is in the costal pleura, directly through

the wall of the thorax, the pulmonary pleura being unbroken. A third form is sometimes noted in which both the pulmonary and costal pleuræ are perforated, but of all these varieties the second is by far the most common. The older writers were in the habit of mentioning another form in which "the cavity of the pleura had no communication with the external air," but it is now almost certain that the unbroken pleural surfaces never secrete air, and that the morbid state can only arise when the pleura is perforated. Dr. F. von Hiemeyer writes: "I will not absolutely deny that decomposition of a pleuritic effusion may give rise to the development of cases in the pleura without the entrance to it of air; but such occurrences are, at least, very rare."

Hillis and Lower, two English physicians who flourished toward the close of the seventeenth century, were probably the first who described a rupture of the pleura followed by the passage of air into the pleural sac, and, still later, Morgagni, in his sixteenth epistle, describes a case with his usual accuracy. Itard, in 1803, was the first to describe it as a substantive disease, though his views as to its origin are quite erroneous, for he fancied that it was always developed after the absorption of a pleuritic exudation. Finally, Laennec gave us a complete monograph in which he so exhausted the subject that little has been added since, save a few particulars as to the physical signs.

Pneumo-thorax occurs most frequently in children four years of age, and especially in those of delicate constitution. Older children are less liable, and they have much better chances of recovery.

The most common cause of pneumo-thorax, in children as in adults, is undoubtedly pulmonary phthisis owing to the rupture of a cavity, and this is most apt to occur when the disease involves the adjacent pleura, leading to its perforation. Out of 131 cases of pneumo-thorax, Saussier found that 81 cases originated in pulmonary phthisis, while in 29 cases empyema was the cause, leaving 21 cases resulting

from pulmonary gangrene, emphysema, etc. Fraentzel, however, ventures to say that of fifteen cases of pneumo-thorax one at most arises from empyema or other processes, and the remaining fourteen arise from vomicæ on the surface of the lungs, in the course of a caseous pneumonia. Pneumonia resulting in superficial abscess is another cause of pneumo-thorax, though it is probable that the pneumonia is most frequently of the "cheesy" variety, really pulmonary phthisis. The croupous variety of pneumonia very rarely leads to pneumo-thorax; the catarrhal is more likely to be the efficient cause. Drs. Meigs and Pepper state that the three cases which they have met were all due to pneumonia, and they report a case in a boy eleven years old, during an attack of secondary pneumonia, complicating a severe bilious remittent fever, where complete recovery ensued, though after a most violent illness. Empyema, with ulceration of the pleura and consequent communication with the bronchial tubes, is still another cause, and this morbid state is likely to assume the form of a pyo-pneumo-thorax. The rupture of an emphysematous bulla situated close to the pleura would result in pneumo-thorax, and this may follow any violent exertion, as coughing, vomiting, or even straining at stool. Injuries to the thorax form another cause, but owing to the elasticity of the costal cartilages this is a less fruitful source in children than in adults.

Sometimes the symptoms of pneumo-thorax are very striking and characteristic, though, when the child is greatly debilitated by the existing disease, the pneumo-thorax is detected with a good deal of difficulty; indeed, death may take place before the medical attendant is quite certain as to the cause of the greatly increased difficulty of breathing. A very sharp and intense pain in the side suddenly appears, accompanied by the most intense dyspnoea, and, when the child is old enough, complaint is made of a feeling as if something had given way. Fraentzel thinks that this pain is not caused by the laceration of the pulmonary pleura, but

by the strong tension which the whole pleural sac experiences. But as all the acute pulmonary diseases of children are accompanied by dyspnœa, it follows that the increased dyspnœa of a child attracts less attention than the same phenomenon in an adult. A violent cough follows the lancinating pain, a short, frequent, and jerking cough, painful and convulsive, with aggravation of the pain in the chest. The voice becomes feeble, and this may progress to complete aphonia. Expectoration, if previously present, ceases from the moment of rupture. The respirations increase in frequency, 50, 60, or even 70 to the minute. The pulse is small, quick, and feeble, and the skin is bathed in cold, clammy sweat. Fraentzel notes that simultaneously with the appearance of the pneumo-thorax, and in pretty direct relation with the other symptoms of venous stasis, there is a diminution in the quantity of urine; it becomes red and dense, and often contains—as urine in venous congestion generally does—small quantities of albumen. The face is pale, and the lips, in extreme cases, are livid. The patient can only lie on the affected side with the head raised, and in a bad case the little one sits bolt upright, so as to get all the air possible.

The course of pneumo-thorax in children is always more rapid than in adults, and death may take place within a few hours of the perforation of the pleura. But, as a general rule, after a period of extreme suffering, a certain intermission takes place, and the patient rallies wonderfully. But secondary pleurisy sets in, the breathing again becomes rapid and painful, the patient becomes cyanotic and dropsical, the dyspnœa increases with the increase of the pleuritic effusion, and the patient slowly sinks, worn out by fever and by the profuse effusion. But the patient may pull through when hope seems entirely lost, and Rilliet and Barthez report a striking case in which recovery ensued after the positive signs of pneumo-thorax had persisted for twenty days in a boy three years of age.

In itself, pneumo-thorax is quite feverless, at least so far as I have noted, but when secondary pleurisy supervenes, as it often does, it is attended by a distinct febrile reaction. No thermometrical observations have been made, and even Wunderlich, all-observing as he is, seems, so far, to have overlooked this morbid state.

The very existence of pneumo-thorax is so closely connected with its physical signs that till these were discovered it remained almost unknown, and accurate views as to its nature only came with the advance of physical diagnosis. The physical signs of pneumo-thorax are both distinctive and remarkable. Inspection shows the affected side of the thorax to be greatly distended, while at the same time the intercostal spaces bulge out. The affected side is immovable, in striking contrast with the exaggerated movements of the healthy side. On measurement it will be found that the diseased side is much larger than the other one.

When the hand is applied to the affected side of the chest, no thrill is felt when the patient speaks, and the vocal fremitus is greatly diminished, or it may be altogether absent. It is always faintest on the affected side. In marked cases, when the left pleura is ruptured, the impulse of the heart is visible to the right of the sternum.

The pleura is distended with air, hence a drum-like, tympanitic sound is the most characteristic, but it must be noted that when the wall of the thorax is very tense, the formation of regular vibrations is interfered with, and the sound is *not* tympanitic, but merely feeble and dull. If effusion extends as a result of secondary pleurisy, then, of course, the percussion-sound becomes dull. Often a distinct metallic clang is heard, especially if the ear is applied to the chest during percussion. If liquid should exist in the pleural cavity at the same time as air,—and this is the rule in advanced cases,—then the percussion-sound is flat, in marked contrast with the drum-like sound occasioned by air alone; and in these interesting cases the limits of the

resonance and of the dullness are clearly defined, the former being above the latter. If the patient sit down, the upper part of the thorax will give a clear tympanitic sound, and the lower part a dull one; if he lie down, the drum-like sound will be anterior and the dull one posterior.

PELVIC HÆMATOCELE.

BY GEORGE ROYAL, M.D., DES MOINES, IOWA.

It is not the object of this paper to give the history, etiology, pathology, or diagnosis of Pelvic Hæmatocele, for they can all be found in our text-books. I simply wish to give the record of a case—the only one I ever treated or have seen, hoping that the perusal of the same may be of some help to some one who may need such help as sorely as I did in this case.

About four o'clock on the morning of the 8th of January, 1889, I was summoned by telephone to the bedside of Mrs. J. B. S., a woman of delicate health, aged twenty-three years. She had a baby aged eight months. She had nursed her babe against my advice, and had menstruated profusely every three weeks since the child was eight weeks old. The result, in spite of china, calc. carb., and as nourishing a diet as we could give, was a condition of marked anæmia. On reaching her bedside, the morning in question, I found her unconscious, almost pulseless, nose pinched and cold, and the body covered with a cold perspiration that stood in large drops all over her face. I at once gave her a dose of acon. 3x, five drops in a tablespoonful of hot water. We then put hot water about the body, and after some twenty minutes she recovered enough to tell me that the menses had appeared three days before, but after flowing four hours they were suppressed for some unknown reason, and had not reappeared. Had felt no particular

effect,—in fact had gone to bed the night before, feeling as well as usual, and had slept till she was awakened by a severe pain in the pelvis. She said to the nurse, "Send for the doctor, I am dying," and then lost consciousness. A few moments later she expressed a desire to go to stool. The movement was a copious one and accompanied with so much pain that she collapsed and did not revive for an hour. During this time acon. 3x and verat. al. 6x were given in alternation every ten minutes. Hot water was also kept about her in bed. I then waited about half an hour and tried to make a vaginal examination, but the least touch of the cervix caused symptoms of syncope, so I desisted. I gave some Cibill's beef hot, and as the pulse became stronger at 8:30 left her and went home to breakfast. Before the meal was half finished I was summoned again and found her just recovering from another sinking spell. She remained conscious till about 10 A.M., when she had another attack. Dr. C. W. Eaton was then sent for. By the time he arrived she had recovered enough to say that she was flowing, and the nurse applied a napkin. Dr. Eaton and I thought this a favorable sign, as the menses had been suppressed, and after seeing constant improvement for an hour we left.

At 1:30 P.M. a message came saying the woman was dying. When we arrived we found, instead of another sinking spell, severe pain in the back and up the spine to the head. She was very restless and delirious. The pupils of the eyes were dilated to their full extent. We gave bell. 12th.

In the evening she was some easier, but the whole pelvic and ovarian region was very sore. The nurse then told me that there had not been a drop of blood on the napkin. Upon learning that there had been a sensation as if the menses had appeared, when in fact they had not, I came to the conclusion that there was internal hemorrhage.

Jan. 9, A.M.—Had passed the night with only one sinking spell; was rational and pupils more normal. Pain in

the back better unless she was raised to a sitting position, when it became worse and syncope would follow. She complained of the least weight of the covering, and said she did not want to sleep, as it made her so much worse. I gave lach. 12th and the bell. 12th in alternation.

Jan. 9, 5 P.M.—Had had a very fair day. Micturition very painful. Same treatment.

Jan. 10.—Pain on voiding urine better. Coughs some and raises large mouthfuls of blood. Bryonia and lach.

Jan. 12.—Has improved slowly till to-day. The cough and expectoration of blood ceased yesterday. On evacuating the bowels the pains were so severe that she fainted. Same treatment.

Jan. 14.—To-day is the first time that the pains have been such as to permit a thorough vaginal examination. This revealed a tumor on the right side of the pelvis, extending to the posterior cul-de-sac. The tumor fluctuates, and motion of the uterus causes severe pain. Gave the same remedies, and, in addition to hot cloths that she had been able to have on the abdomen for two days, ordered injections of hot water every four hours. The headache and pain in the back and spine are nearly gone.

Jan. 15.—Called because of a very severe epistaxis. Gave ham. and lach.

Jan. 17.—Called in haste. The patient was delirious. The face and whole body were, as the nurse expressed it, as yellow as saffron. The night before she had complained of a constant ringing in the ears. I gave china and lach.

Jan. 18.—Some better. Same treatment.

Jan. 20.—Has been on china 3x and the lach. with constant improvement. The color of skin much better. No more ringing in the ears. Examination showed the tumor much smaller.

Jan. 21.—The menses have come on. Flow very watery and scant. Same treatment.

Jan. 25.—Flow lasted two days. Improving every way.

Can sit up now at an angle of 45° without pressure and pain in pelvis. Same treatment.

On these two remedies and with the aid of hot water she steadily improved in strength. The tumor grew less in size, and the pains less severe, till now she is about her usual duties.

On March 18 the tumor was no larger than an English walnut and about the consistency of an orange.

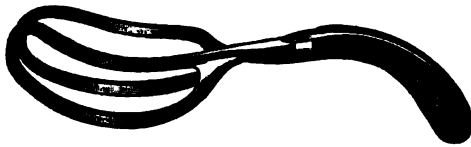
HALE'S OBSTETRIC FORCEPS.

BY EDWIN M. HALE, M.D., CHICAGO.

It is now nearly twenty years since I designed and introduced my short forceps. The idea was original with myself. Prior to that time no forceps as small and light as mine had been devised. They were first manufactured and sold by E. H. Sargent & Co. of Chicago. There was nothing especially new about the blades, except that they were much thinner and therefore lighter than any other. It was the *handle* that was unique. It had often occurred to me that for delivery of the child in the lower strait—the blades of all forceps were unnecessarily heavy, but there was a greater objection to the universally *straight* handle. It was both awkward and clumsy. It appeared to me that a handle such as pistols have was more nearly the proper shape. For my small forceps I designed the pistol handle, but it was such an innovation that I had a good deal of difficulty in persuading the manufacturer to adopt it. But it proved very popular, and the sale of the instrument was very large. Many obstetricians designed forceps imitating it with trifling variations. But as an illustration of the difficulty of overcoming the conservatism of instrument-makers, I have had great difficulty in perpetuating the true curve of the handle. All makers have made handles with a less curve than my original design.

I have never heard but one objection made to the extreme downward curve of the handle of the small forceps. It was that it was difficult to apply it with the woman's hips entirely *on* the bed, on the back or side. Now, this objection is untenable, for the forceps was never intended to be applied before the child's head was in the inferior strait, or resting on the perineum, and when any forceps is applied at that time, the handle points *upward*, or nearly so, and cannot by any possibility touch the bed.

The failure of the instrument-makers to adhere to my original design decided me to superintend the manufacture of a correct instrument. I applied to the firm of Charles Truax & Co. of Chicago, and under my direction they have made an ideal forceps, which is shown in the following cut:



The measurements of these forceps are as follows: Whole length following curve of handle, upper side, 13 inches; length on straight line, 12 inches; length of blades, 6 inches; length of handle, 6 inches. It has a single English lock (the first design had a button lock). The handles, cased in wood, are smooth, to prevent accumulation of septic matter. The weight is $11\frac{1}{4}$ ounces; greatest width between the blades, $2\frac{1}{2}$ inches; width at top, 1 inch.

Mr. Truax has lately made another style with metal handles, with shallow fluting, weighing one ounce more. This is a perfectly aseptic instrument, for it can be placed in boiling water.

I have written this history of my forceps, and given the dimensions and cuts, in order that there shall be no further excuse for deviating from my design. Many physicians who have purchased and used the forceps alleged to be my instrument have not been satisfied with them, because they

have been clumsy and ill-shapen. To such I would say, procure a genuine instrument from Truax & Co., or Gross and Delbridge of Chicago, and you will find them artistically and delicately fashioned.

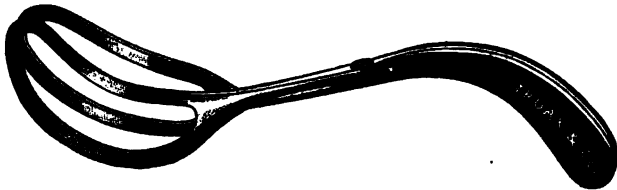
I append the following letter from Dr. Sheldon Leavitt, Professor of Clinical Midwifery, and author of "A System of Obstetrics," who thus expresses his appreciation of the small forceps :

CHICAGO, January 12, 1889.

DEAR DR. HALE: I have just been presented by Truax & Co. with a pair of your short forceps with the lock improved as suggested by me. Now you truly have a fine instrument, and by slightly enlarging it you have increased its range of application without making it cumbersome and formidable.

Truly yours,

S. LEAVITT.



About five years after the small forceps was introduced, I designed a larger, longer, and heavier instrument. It had the same curved pistol-handle. This met with the same fate at the hands of the instrument-makers, who could not or would not appreciate the value of the handle I designed. Consequently but few have ever been made as I originally designed. Mr. Truax has, however, manufactured the instrument to suit me. It resembles the small forceps, but it has the typical pelvic curve, which enables it to reach and grasp the head not only in the superior strait, but above, even before the head has engaged.

The extreme curve of the handles is no objection, because in cases when it should be used, the woman's hips are always brought to the edge of the bed and often projecting over. I have used these forceps in cases when it seemed that none

but Tarnier's could be used; but the traction, when directed by the hand grasping the *end* of the handle, acts in nearly the same manner as when Tarnier's is used. Its use is not restricted to the high operation, but in certain cases can be used instead of short forceps.

The measurements of this instrument are: Whole length following curves, upper side, 17 inches; length on straight line, $15\frac{1}{2}$ inches; length of blades, 6 inches; length of handles, 7 inches. It has a button lock. The handles cased in wood, smooth, or all metal, fluted. The weight is 19 and 20 ounces. Greatest width between blades, $2\frac{1}{2}$ inches; between top of blades, $\frac{1}{2}$ inch.

LACERATION OF THE CERVIX UTERI.

BY W. D. FOSTER, M.D., KANSAS CITY, MO.

Mrs. D. C. S., æt. twenty-nine, married in 1880. First menstruation in her fourteenth year, in November. Continued regular till February, then stopped entirely till September. Suffered very much during those months when menses were absent, with cramps in the lower extremities, and lassitude. During the menses had pains the first day, but not severe enough to go to bed, and not any after. Menses lasted four or five days. General health good; had occasional bilious attacks and headaches. Married in her twenty-first year. Has been married eight years, and has given birth to four children, to wit:

No. 1. A boy born October 17, 1881; weight, $5\frac{1}{2}$ pounds; tedious labor lasting fifteen hours; presentation natural; perineum slightly ruptured; recovery fair. The boy died on the fourth day, from congestion of the lungs.

No. 2. A boy, Allenth, born April 14, 1883; weight, $7\frac{1}{2}$ pounds. While carrying this child, suffered intense pain in uterus, particularly in the morning; labor lasted ten hours;

natural presentation ; pains more severe than before ; quick and fair recovery. Nursed baby one year.

No. 3. A girl, Annie, born January 2, 1885 ; weight, 8 pounds ; labor lasted ten hours ; very hard. Had undergone treatment in first months of pregnancy for ulceration, leucorrhœa, prolapsus, etc. Got up on seventh day, and six weeks afterward had retroversion. Nursed the baby one year.

No. 4. A girl, Sidney, born June 14, 1887 ; weight, 7½ pounds ; last labor ; natural presentation ; labor rapid, lasting four hours. Pain in the uterus very much worse during this period of gestation—although never without pain since first labor. Nursed last child sixteen months. Has never been well since the birth of first child.

The foregoing history is in the words of the patient, and conveys a clear clue to the difficulty, which is confirmed by subsequent physical examination.

A reference to Emmet's Tables shows that more than 30 per cent. of his cases of laceration were caused by, or followed, tedious labors. This lady's first labor lasted fifteen hours ; the baby, though small, was fairly vigorous, and promised well. A study of this history clearly shows that lesion was incurred at first labor. During the second and fourth labors the writer was in personal attendance. Mrs. S. was imprudent in getting up, and inclined generally to overdo herself.

Sept. 22, 1887, examination revealed lacerated cervix ; retroversion, with subinvolution, profuse leucorrhœa. She had backache ; much peritoneal soreness : irritation of the bladder. At this time she got some tampons ; the cervix was painted with tr. iodine comp. ; she was directed to take hot vaginal douches three times a week on retiring at night. She speedily improved, and gave up treatment.

In October, 1888, she came to me with a bad cough and copious purulent expectoration ; the erosions on the os uteri were very raw, much everted, granulating, and bled on

the slightest touch. Leucorrhœa had again become ropy and profuse; backache had returned; she slept badly and was altogether in a melancholy plight. I now advised an operation, to which she consented. After several weeks' preparatory treatment, on January 2, 1889, five days after the cessation of the menstrual flow, and assisted by Drs. Moses T. Runnels, Geo. Merwin, and L. J. Olmsted, I proceeded to dissect out the cicatricial tissue: five wire sutures were required on the left, and three on the right side. On January 10, upon removal of the wires, union was found perfect. No complications arose, and she got up on fourteenth day after the operation. Her cough immediately abated, and was practically relieved when she got out of bed. This patient has steadily improved—gaining in strength and weight: the cough now, March 25, has entirely disappeared, and she expressed herself as being very grateful that she once more felt well.

SYMPHORICARPUS.

A CONTINUATION OF THE SERIES OF STUDIES OF NEW
REMEDIES IN GYNÆCOLOGY.

BY PHIL. PORTER, M.D. CINCINNATI, O.

Synonym, Symphoricarpus Racemosus; *Natural Order*,
Caprifolaceæ; *Common Name*, Snow Berry.

When Professor S. P. Burdick, while investigating the medical properties of this drug, gave some of it to his first prover, the marked feeling of nausea which it produced caused her to exclaim, "Doctor, this is precisely like the morning sickness I always experience during pregnancy." With other female provers it produced almost uniformly the same results, "a feeling varying from qualmishness to intense nausea with violent vomiting." Upon these indica-

tions Dr. Burdick gave it in the higher potencies to patients suffering from the vomiting of pregnancy, with the most satisfactory results. Following the fragmentary provings and the clinical experience of Dr. Burdick with *symphoricarpus*, Dr. Edward V. Moffatt has more lately called attention to the drug so far as he has been able to estimate its sphere. He says:

"The indications, so far as I have observed them in cases of pregnancy, are a feeling of qualmishness, with indifference to food.

"In more severe cases, like the above, there is deadly nausea; the vomiting is a continuous and violent retching, but it covers every gradation between these extremes. It does not seem to be confined to any particular *morning* aggravation. A prominent symptom is the disgust at the sight, smell, or thought of food.

"One case I remember in which the patient was comparatively comfortable while lying on the back, but would be nauseated by the slightest motion of the arms, particularly raising them. This case was completely relieved by a few doses. And so the cases might be multiplied."

In the case of a young lady three months advanced in her first pregnancy, who was suffering from a deadly nausea with vomiting and retching so prolonged and violent as to produce hæmatemesis, *symphoricarpus* stopped the vomiting and quieted her. In this case the smell or thought of food was repugnant in the extreme. In other cases in which Dr. Moffatt prescribed the drug, the results were so gratifying that some of it was sent to his father, brother, Dr. Danforth, both Drs. McClelland of Pittsburg, and several others, all of whom reported favorably.

Besides the reflex gastric disturbances of pregnancy, it has been given repeatedly in cases of nausea or vomiting, before or after the catamenia, with admirable results. Again, apart from menstruation, it has proved beneficial in certain cases of irritable or congested ovary, hysteria, and ovarian tumor.

CONCORDANCE REPERTORY OF THE MOST RELIABLE SYMPTOMS OF THE FEMALE SEX- UAL ORGANS FOUND IN THE MATERIA MEDICA.

BY WILLIAM D. GENTRY, M.D.

The following is a copy of all symptoms on the subject of the menses, or in which the word "menses" occurs, found in the above-named forthcoming work. Published by permission of the author. (See note by the author on page 234.)

Delayed m. Abeis-n., Camph., Cic-v.

Promotes the m. Absinth.

M.: too early. Cact., Caul., Clem., Colch., Ign.

M.: too early and profuse. Ambr., Am-c., Ars., Bell., Bov., Calc-c., Canth., Carbo-v., Cina, Croc., Cycl., Grat., Ipec., Laur., Led., Lob., Magn-m., Mur-ac., Merc-cor., Rhus-t., Sulph-ac.

M.: too early, too profuse, and last too long. Ars., Bell., Calc-c., Diad., Kali-c., Mez., Natr-m., Nux-v., Phos., Petr., Rhus-t., Sabin., Sec., Ver-a.

Suppressed m. Acon., Berb., Brom., Cimicif., Hell., Kali-Jod., Kali-n., Magn-m., Nitr-ac., Puls., Rhod., Senecio, Sil., Tarax., Ustil.

Re-appearance of m., which has been arrested by a cold bath. Acon.

M.: too late, too scanty. Hep-s., Magn-c., Natr-s., Puls., Tilia.

M.: suppressed, too late and scanty. Coni.

M.: too early and too profuse. Calc-c., Grat., Gum-gut. Difficult first m. Caust., Graph., Kali-c., Puls., Sulph.

Dysmenorrhœa, or suppressed m. Abrot.

M.: suppressed from fright, vexation, cold; especially in plethoric women. Acon.

Ovaritis; painful urging to urinate; high fever; also, after the m., are suddenly checked. Acon.

M.: generally too late; diminished, but too protracted;

plethoric females who lead a sedentary life; tendency of blood to head and chest; profuse with nose-bleed suppressed by fright, with vexation. Acon.

Leucorrhœa; dark yellow, thick and sticky; worse after m.; worse walking; corrodes the labia; aching in the sacrum and knees. Æsc.

M.: too profuse, with tearing, pressive pains in the back and abdomen. Agar.

Prolapsus-uteri, after cessation of m. Agar.

Pain in the hypogastrium as if m. were coming on. Aloe., Caul., Cimicif., Puls., Sang.

M.: scanty, pale and painful. Alu., Phos.

After m., great exhaustion in the body and mind. Alu., Am-c., Cocc.

M.: too early, short, scanty, and of pale blood; too early, preceded by headache; delay, finally appear, being pale and scanty. Alu.

Colic before and during m. Ambr.

Leucorrhœa excoriating, before and after m. Alu.

M.: perhaps regular, or too early, but are very profuse; accompanied by nose-bleed and varicose veins if they are present. Ambr.

During the m., the left leg becomes quite blue from the distended varices, with pressive pain in the leg. Ambr.

Cholera-like symptoms at the commencement of the m. Am-c.

Great fatigue of the whole body during m. (Carbo-an., Cocc.), especially of the thighs, with yawning, toothache, pain in small of back, and chilliness. Am-c.

M.: premature, abundant; preceded by griping, colic, and want of appetite; too late, scanty, and short; blackish in clots; and passing off with pain in abdomen; acrid, making thighs sore; very slightly colored. Am-c.

Pollutions, colic, and pains in sacrum during m. Am-c.

M.: too early, with pain in abdomen and small of back, continuing at night, when the flow is more abundant. Am-m.

- Blood from rectum during m. Am-c.
 During m. a bloody discharge from the bowels. Am-m.
 M.: too early, too profuse, with pain in the back. Am-m.
 Vomiting and diarrhœa during m. Am-m.
 M.: commenced at an early period, are profuse, then cease; subsequently chlorosis. Ant-c.
 Before m., toothache, boring in the temples. Ant-c.
 M.: too early, weak, and only for two days. Tart-em.
 Before m., pain in the groins and cold creepings. Tart-em.
 Pain and sensitiveness in right ovarian region during m. Apis.
 Sharp, cutting, stinging pain in the swollen ovary; worse during m. Apis.
 Suppressed m., with congested or inflamed ovaries. Apis.
 Inflammation of the right ovary (left, Lach.), worse during m. Apis.
 Suppressed m., with congestion to head (Calc-c., Glon., Graph.), with nose-bleed. Apis, Bry.
 M.: irregular, too copious or too scanty, too soon or too late. Arg-n.
 M.: too early, profuse, long-lasting, with headache, cutting in the small of back and groin; at night tormenting pressure in præcordia; internal trembling in epigastrium; irregular, too soon or too late, too copious or too scanty; but always with thick coagulated blood. Arg-n.
 M.: generally too soon, nausea in the epigastrium. Arn.
 Thin, whitish, offensive discharge instead of the m. Ars.
 M.: too early, profuse (Ambr., Am-c., Calc-c., Nux-v), exhaustion (Alu., Carbo-an., Cocc.), dark blood. Ars.
 Scanty, pale m. Ars.
 M.: too frequent, too scanty, and last but a short time. Asaf.
 Suppression of m. (during dropsy). Aster.
 M.: delayed, but more abundant than usual. Aster.
 M.: scanty, last but one day. Bar-c.
 Before the m., toothache, swollen gums, colic with

swelling of the limbs immediately before leucorrhœa. Bar-c.

M.: too early, dysmenorrhœa, blood dark, tarry, passing in clots. Am-m.

M.; too late, scanty, preceded by swelling of axillary glands; accompanied by colic, prolapsus of the rectum. Aur-m.

Uterus prolapsed and indurated; bruised pain, with shooting or drawing; heaviness in abdomen; after lifting a heavy load; worse at time of m. Aur-m.

At the appearance of the m., violent pain in small of back, which scarcely permits her to breathe. Asar.

During the m., weight over the pubes; bruised pain in small of back. Bar-c.

M.: too early, too profuse (Am-c., Calc-c.) bright red blood (Ham., Ipec.), or thick, decomposed, dark, red blood. Bell.

M.: too scanty and painful, gray mucus or blood. Berb.

M.: scanty, painful, blood is more like serum. Berb.

Pain from the stomach to the small of the back before the m. Borax.

Stitching, tearing pains in groins at time of m. Borax.

Leucorrhœa a few days before or a few days after the m., like white of egg (Aur-m., Borax, Calc-ph., Mez.), when walking. Bov.

M.: every two weeks, much dark clotted blood; too late; only at night, or only in the morning. Bov.

Before m., diarrhœa; during m., headache; after m., leucorrhœa of thick, slimy, tenacious, acrid, corrosive mucus. Bov.

M.: flow most in morning; scanty during day and night. Bov.

M.: cease flowing at night. Cact., Caust.

M.: more profuse at night (Magn-c., Zinc.); only in morning (Sep.); only morning and evening (Phell.); only in afternoon. Bov., Magn-c.

M.: too early, too profuse (Ars., Calc-c., of Nux-v.);

bright red blood (Bell., Ipec.); flow passive with much exhaustion (Carbo-an., China), or membranous shreds may pass off. Brom., Cycl.

Headache on appearance of m. Brom.

Violent contractive spasm before and during m., lasting hours, leaving abdomen sore. Brom.

M.: too early, with headache. Bufo.

During m., pain in abdomen and small of back. Brom.

M.: suppressed, with nose-bleed; with congestions. Apis, Bry., Calc-c., Glon., Graph.

M.: too soon, black, pitch-like. Cact.

M.: cease on lying down. Bov., Cact., Caust.

M.: of dark blood. Cact.

Suppressed m., with full habit; after working in water. Calc-c.

Swelling and painfulness of the mammæ before the m. Calc-c., Coni., Lyc., Murex, Nitr-ac., Ox-ac., Phyt.

During m., cutting in abdomen, griping in the back, heat in head. Calc-c.

Leucorrhœa like milk, burning, in starts; before m.; during micturition. Calc-c.

Sterility, when the m. are too early and too copious. Calc-c.

M.: too early, bright red, with girls; too late, blood dark, or first bright, then dark, with women. Calc-ph.

M.: increased; delayed. Camph.

M.: too early, too profuse, blood black or scanty. Canth.

Too profuse m. with dysuria. Can-sat.

During m., nausea, pressure in the epigastrium. Caps.

M.: disordered, with a pushing or stinging sensation in the left ovarian region. Caps.

M.: profuse, and dark colored. Carbo-ac.

During m., so exhausted that she can hardly speak. Alu., Am-c., Carbo-an., Cocc.

During m. lameness in thighs; pressing in small of back, groins, and thighs; unsuccessful desire to eructate, chilly,

yawning; the flow weakens her, she can hardly speak; blood black. Carbo-an.

M.: too early, too profuse; blood too thick and of a strong odor. Carbo-v.

M.: too early, too profuse; blood pale or thick, corrosive, acrid smelling. Carbo-v.

Three days after cessation of m., discharge of lumps of tenacious black blood, profuse leucorrhœa following. Carlsb.

Scanty, retarded m., at times more profuse, and lasting too long; then somewhat darker blood and of a penetrating smell. Carlsb.

Difficult m. (Cimicif., Senecio), with drawing in loins and pains in front part of thighs. Carlsb.

Painful m., the flow being normal in quantity. Caul.

Cutting colic and diarrhœa during m. Caust.

Leucorrhœa, profuse, flow like m. and have the same odor. Caust.

M.: too early, too profuse, and often ceasing; a little is passing from time to time for days. Caust.

Pain in back during m. Caust.

M.: too early, too profuse, offensive. Cham.

M.: too late, too profuse, and of too long duration. Chelid.

Spasmodic state, if the m. do not appear. Cic-v.

Tearing and drawing in the os coccygis during m. Cic-v.

M.: irregular, delayed or suppressed. Cimicif., Puls., Senecio, Sep.

Hysterical or epileptical spasms at time of m. Cimicif., Hyos.

M.: profuse, early, dark blood; coagulated. Cimicif.

Debility between the periods; scanty flow between the m.; suppressed by mental emotions; from cold; from fever. Cimicif.

Pain in abdomen, as if m. would appear. China.

Leucorrhœa, instead of or before m.; with spasmodic uterine contractions. China.

M. : too early, profuse, black clots, with spasm in chest and abdomen. China.

Painful bearing down to vulva and anus; m. increased. China.

M. : after being delayed, come in gushes, awakening from a sound sleep. Coca.

M. : too early, with cramps in the abdomen and colic pains. Cocc.

Suppression of m., with cramps in the chest and fainting; nausea. Cocc.

During m., so weak that she can scarcely stand or talk. Alu., Am-c., Carbo-an., Cocc.

Leucorrhœa instead of m., like serum, mixed with a purulent ichorous liquid. Cocc.

M. : too profuse and of too long duration. Coff.

M. : profuse and too often; when rising upon feet, it gushes out in a stream. Cocc.

M. : too early or suppressed, blood clotted, with uterine spasms, or abdominal colic. Cocc.

M. : profuse with coldness and stiffness of the body. Coff.

M. : only during evening. Coff.

Suppression of the m., caused by chagrin. Coloc.

Soreness and swelling of the breasts preceding the m. Coni.

Pressure from above downward, and drawing in legs during m. Coni.

Sensation as if the m. would appear, with colic and pressing toward the genitals. Caul., Cimicif., Croc., Puls.

M. : profuse, and lasting too long, but come at proper time; blood dark, clotted, and stringing. Croc.

Dysmenorrhœa before m. Croton-tig.

Before or during m., or after suppression, violent unbearable cramps in abdomen, extending up into chest, causing nausea, vomiting, and sometimes convulsions of limbs and piercing shrieks. Cupr.

M.: not appearing after the suppression of foot-sweat.
Cupr.

Before m., spasmodic dyspnœa. Cupr.

M.: blood black (Kali-n.), clotted (Am-c., Croc., Ign., Plat.) and membranous. Brom., Cycl.

M.: too profuse and too frequent. Cycl.

After m., swelling of mammæ, with secretion like milk.
Cycl.

Labor-like pains in abdomen and back before m. Dig.

Rash before the m. (during, Kali-c.). Dulc.

M.: milk or lochia suppressed by cold. Acon., Cimicif., Dulc., Puls.

M.: too late, too short; blood watery, thin. Dulc.

M.: painful, lasting only one hour; time regular. Euph.

M.: late, scanty, and of short duration. Euph.

M.: too late, long-lasting, and profuse. Ferr.

Before m., stinging headache, ringing in ears, discharge of long pieces of mucus from the uterus. Ferr.

Hysterical symptoms after m. Ferr.

Hysterical symptoms from suppressed m. Ferr.

M.: flow watery or in lumps; preceded by labor-like pains. Ferr.

M.: varices in legs, worse; intermit two or three days, then returns. Ferr.

M.: uterus displaced; come on with a physical languor and mental depression, unfitting her for work. Ferr.

M.: too early, too copious, discharge thick and coagulated. Fluor-ac.

M.: suppressed with congestion to the head. Gels.

M.: suppressed, sharp, darting, twitching pains in the face and head. Gels.

M.: suppressed; convulsions. Gels.

Instead of m., congestion to head. Glon.

Before, during, and after m., or when it does not appear, fullness in the head. Glon.

M.: too late, too scanty, too pale. Graph., Puls.

Pain in epigastrium during m., as if everything would be torn to pieces. Graph.

Itching of the pudenda before m. Graph.

Morning sickness of pregnancy, or during m. Graph., Kali-c., Lact-ac., Puls., Sep.

M. : with violent colic, blood sometimes dark. Graph.

During the m., heat in the abdomen. Graph.

Copious leucorrhœa before and after the m. Graph.

Colic, headache, nausea, during m. Graph.

M. : irregular. Ham.

Diffused, agonizing soreness over the whole abdomen, worse at time of m. Ham.

M. : too frequent and profuse in women who are feeble from loss of blood. Helon.

Hysterical pain or spasm preceding the m. Hyos.

During m., convulsive trembling of hands and feet, headache, nausea, and profuse perspiration. Hyos.

Very profuse flow of the m. Hyos.

M. : preceded by hysterical or epileptic spasms. Cimicif., Hyos.

During m., convulsive movements; headache. Hyos.

M. : too late, with tension in the uterine region, as from a tight bandage. Hyper.

M. : increased in quantity. Hyper.

Suppression of the m., with dropsical affections. Kali-c.

Three days before their appearance, pinching in the abdomen, diarrhœa, cold feet. Hyper.

Leucorrhœa, with delayed m.; palpitation, pressure in the small of the back, and heaviness in the lower bowels. Hyper.

During uterine spasms (Murex.), relieved by pressure and in recumbent posture. Ign.

Leucorrhœa, acrid, worse at time of m. Iod.

M. : sometimes too early, at others too late. Iod.

M. : premature, violent, and copious. Iod.

M. : too early, with giddiness, nausea, and headache. Kali-bi.

M.: too soon, with vertigo, headache, nausea, and feverishness. Kali-bi.

Before m., sour eructations. Kali-c.

During m., headache, with heaviness. Kali-c.

M.: suppressed or too early, too scanty (Sil.), blood acrid, corroding thighs; during m., colic, weight in small of back, headache. Kali-c.

During m., thighs feel as if squeezed. Kali-jod.

Frequent urging to urinate, when the m., appear. Kali-jod.

M.: eight to twenty-four hours too soon. Kalm.

During m., pain in limbs, loins, back and interior of thighs. Kalm.

Leucorrhœa, yellowish, one week after m.; symptoms are more prominent then. Kalm.

M.: and leucorrhœa inclined to be intermittent; patient thinks she is almost well, when the discharge returns again. Kreos.

M.: succeeded by an acrid-smelling bloody ichor, with itching and biting in the parts. Kreos.

M.: more or less painful during the flow, but much aggravated after it. Kreos.

M.: flow intermits, at times almost ceasing, then recommencing. Kreos.

M.: scanty, feeble, but regular. Lach.

Labor-like pains during m. Caul., Cimicif, Lach., Puls.

M.: blood thin. Laur.

M.: with nightly tearing in the vertex. Laur.

M.: the blood is bright red. Led.

M.: absence of vital heat. Led.

M.: suppressed or retarded. Lept.

M.: flow only, when moving about. Lil-tig.

M.: dark, thick, smelling like the lochia. Lil-tig.

M.: too late, scanty, cease suddenly and headache comes on. Lith-c.

M.: profuse, protracted; flow partly bright red or partly serum. Lyc.

- M. : stop in the afternoon. Magn-c.
 M. : flow acrid, dark, pitch-like. Magn-c.
 M. : preceded by labor-like pains, cutting in the abdomen, sore throat, weakness, chilliness, back-ache. Kali-c.
 M. : flowing more at night and at first on rising; also between uterine pains. Magn-c.
 M. : more profuse at night than during the day. Magn-c.
 During m., face is pale, with pain in loins and mental depression. Magn-m.
 M. : profuse and early, or late, with violent pains, which are worse in the back when walking and in the thighs when sitting. Magn-m.
 M. : pale face, debility, nervous excitement. Magn-m.
 M. : too profuse, with anxiety and colic. Merc.
 M. : with either sterility or easy conception. Merc.
 Milk in the breasts instead of the m. Merc.
 M. : scanty, with leucorrhœa and prosopalgia. Mez.
 M. : suppressed or too profuse. Millef.
 M. : suppressed, with pain in the stomach. Millef.
 M. : epilepsy. Millef.
 M. : cough, with bloody sputum. Millef.
 M. : excessive flow, lasts too long; also with colic pains. Millef.
 Sterility, with too profuse m. Millef.
 Pressing on genitals, as if m. would appear. Mur-ac.
 Pressure in the hypogastrium, as if everything would come out, and the m. come on. Bell., Natr-c., Sep.
 M. : too early, too long-lasting; preceded by drawing in the nape of neck and headache; accompanied by tearing headache, distended abdomen in the morning, relieved by diarrhœa; nervousness, cannot bear music; worse in a thunderstorm. Natr-c.
 Sterility, with too early and too profuse m. Natr-m.
 During m., sadness, headache, colic. Natr-m.
 Before m., anxious, sad, qualmish, sweetish eructations; in the morning headache, eyes heavy, palpitation. Natr-m.

After m., headache. Natr-m.

M.: too late; blood acrid, making thighs sore; lumps of coagulated blood. Natr-s.

M.: too late, flows freely when walking. Natr-s.

M.: irregular, scanty, and like muddy water; early and profuse; aching from the thighs; urine offensive. Nitr-ac.

M.: irregular in time and quantity, flow generally dark and thick. Nux-m.

During m., great pressure in the back, from within outward. Nux-m.

M.: limbs feel weak, ache; pain in small of back, as if a piece of wood were lying crosswise and being pressed out; pain in uterus at the outset; tension in hypogastrium; mouth dry; unconquerable drowsiness; profuse, with fainting; hysteric laughing, worse in open air; scanty or suppressed from fright; from debility; from a cold; over-exertion; cramps low down in left lower abdomen; worse when sitting. Nux-m.

M.: staining linen like iron-rust, cannot be removed by washing. Phos.

During m., nausea in the morning, with chilliness and attacks of faintness. Nux-v.

M.: flow dark, over-sensitiveness to nervous impressions. Nux-v.

During m., faints easily. Nux-v.

M.: profuse, violent colic, forcing her to bend over; urging to stool. Opi.

M.: flow while nursing. Pallad., Sil.

M.: too early, the discharge causes itching. Petr.

Before the m., throbbing in the head; during m., singing and roaring in the ears. Petr.

M.: too early, and too scanty, or too profuse; pale, with colic, nausea, and diarrhœa. Phos.

Sterility from excessive voluptuousness or with late and profuse m. Phos.

M.: suppressed with milk in the mammæ. Phos. 4

Weeps before the m.; during m. pains in the small of the back; palpitation. Phos.

Pain in the liver during m. Phos-ac.

Profuse yellow leucorrhœa, mostly after the m.; with itching. Phos-ac.

Pain as if m. were coming on. Physos.

Painful m. in barren women. Phyt.

M.: too frequent and too copious, mammæ painful. Phyt.

Cataleptic attacks during m. Plat.

M.: too early, too profuse, (Calc.-c., Nux-v.), lasting too long, flow dark and clotted (Am.-c., Cycl., Croc., Ign.); with much bearing down and drawing pains in abdomen. Plat.

During m., melancholy. Plat.

Cessation of m., on invasion of colic; may reappear after paroxysm or not again until next period. Plumb.

Suppressed m. in young females, with bearing down in hypogastric and sacral regions, with pains from motion; better lying down. Podo.

During m., and with uterine troubles, heavy, pressing pain in abdomen and small of back, as from a stone (Alu., Cimicif., Caul.), limbs tend to go to sleep; ineffectual urging to stool. Puls.

M.: suppressed after getting feet wet. Puls.

M.: too late scanty and of short duration (Cimicif., Sulph.); suppressed or flow intermittent (Cimicif.); flow thick and black (Ign.), more during the day, while walking about (at night, Magn-c). Puls.

M.: in chlorosis; from nervous debility with throbbing headache; pressure in stomach; pain in uterus; dysuria; ophthalmia; morning nausea, or bad taste in mouth. Puls.

M.: too early, too profuse. (Calc.-c.) lasting too long, with pains in abdomen and back; metrorrhagia. Rat.

M.: too profuse, too early, with fever and headache; m., suppressed. Rhod.

M.: flow light-colored and acrid, causing biting pain in the vulva. Rhust.

Corrosive leucorrhœa, after regular suppressed m. Ruta.

M.: too late, with painful bearing down a few days previous; decrease, flow by fits and starts, and irregularly; sometimes weaker. Sabad.

Abdominal pains as if m. would appear. Aloe., Caul., Cimicif., Puls., Sang.

M.: at night-time, offensive-smelling, bright-red flow; clots, like lumps of flesh; later, blood darker and less offensive, scanty, headache from occiput to frontal region: head as if bursting; face red and hot. Sang.

M.: too late and scanty, preceded by urging to urinate; itching eruption on forehead; flow acrid; soreness inside of thighs. Sars.

During m., griping in pit of stomach, in direction of small of back. Sars.

M.: copious and dark. Selen.

M.: suppressed from cold. Cimicif., Puls., Senecio.

M.: regular, but scanty. Nux-v., Sep.

M.: Irregular m., at times too soon, at times retarded. Senecio.

During m., toothache, headache, epistaxis. Sep.

Neuralgia of left side of face and temples with retarded m. Lob.

Increased m., with repeated paroxysms of icy coldness over the whole body. Sil.

M.: too early and too feeble. Sil.

M.: too early and scanty; too late and too profuse; irregular, every two or three months; flow strong-smelling and acrid. Sil.

M.: too soon, too profuse; preceded by colic, backache, soreness in sacrum, and craving in the stomach; palpitation. Spong.

During m., drawing in all the limbs; awakens with suffocating spells. Spong.

M.: too early and profuse, preceded by melancholy ; pain in malar bones, which continue during m. Stann.

M.: irregular, late and profuse, sometimes wanting ; first pale blood, then dark and clotted ; occasionally spasmodic uterine contractions. Staph.

M.: flow very watery. Stram.

After m., sobbing and whining. Stram.

Body smells offensive during m. Stram.

M.: too late ; first discharge of serous, later, clotted. Stront.

M.: thick, dark and excoriating blood. Am-c., Sulph.

During m., nose-bleed, headache (Bry., Ham.) ; pressure in pit of stomach ; before m., headache. Sulph.

Distressing nightmare before m. Sulph-ac.

Leucorrhœa of sanguineous mucus, with a sensation as if m. would appear. Sulph-ac.

M.: too short and too early, succeeded by profuse sweat. Thuja.

M.: flow too profuse after exhaustion by exercise. Trill.

M.: come on after over-exertion, too long a ride, etc. ; profuse flow. Trill.

Leucorrhœa bloody with great prostration ; yellow, creamy, profuse between m. Trill.

M.: scanty, with ovarian irritation. Ustil.

Between m., constant pain under left mammæ, at margin of ribs. Ustil.

M.: profuse, frequent, continuing coagula. Ustil.

Suppressed m., with despair of salvation. Ver-a.

Nymphomania before m. Ver-a.

During m., morning headache, nausea, ringing in the ears, pains in the limbs. Ver-a.

Wants to kiss everybody just before m. Ver-a.

Suppressed m., with cerebral congestion, plethora. Ver-v.

Before m., severe bearing down, drawing in anterior muscles of thighs ; heavy aching in sacral region and over pubes ; occasional sharp shooting pain in ovaries ; pains

make her so nervous, she cannot sit still; excruciating, cramping, colicky pains in lower abdomen and through womb; pains begin in back and go around, ending in cramps in the uterus. Vib-op.

During m., nausea; cramping pain and great nervous restlessness; flow ceases for several hours, then returns in clots. Vib-op.

Congestive feeling in pelvic organs as if m. would appear. Vib-op.

M.: excessive, profuse, flow in streams, with great debility. China, Vinca.

M.: too early, or suppressed and painful. Zinc.

• Dysmenorrhœa, when during m. limbs feel heavy; with violent drawing about knees, as if they would be twisted off. Zinc.

M.: too early and profuse, lumps of coagulated blood pass away, mostly when walking; flow most profuse at night. Zinc.

Leucorrhœa of bloody mucus after m., causing itching of the vulva. Zinc.

Leucorrhœa of thick mucus, three days before and after the m. Zinc.

M.: too early and profuse, dark and clotted. Zing.

Delay of first m. Dros., Graph., Lyc., Natr-m., Puls.

Bleeding of the nose, particularly early in the morning or after rising; during the suppression of the m. Bry.

Prolapsus and hemorrhages during m. Ipec.

Great soreness about the genitals before, during, and after m. Kali-c.

M.: too profuse, blood black and clotted. Stram.

Chilliness during m. Ver-a.

M.: too early and too scanty. Coni., Kali-c, Mang., Sil., Stront.

M.: too profuse. Murex.

Exhausted look before m., irritable. Zing.

Drawing pain in sacrum during m. Zing.

M.: too scanty. Caust., Croton-tig., Lil-tig.
 M.: blood black. Lach.
 M.: too early, too scanty, or too profuse. Am-c.
 M.: cease at night on lying down. Bov. Cact., Caust.
 M.: too late but profuse. Caust.
 Discharge of blood between m. Hep-s.
 M.: only in morning. Sep.
 Frequent sensation as if m. would appear. Plat.
 Diarrhœa frequently before and during m. Bov.
 Mania, with profuse m. Sep.

MENSTRUAL.

M.: blood blackish, in clots, (Croc., Cycl., Ign., Plat.)
 acrid, makes thighs sore. Am-c., Sulph.
 M.: blood darker. Arum.
 M.: colic. Caul.
 At every m. effort, the breasts become sore and painful.
 Coni.
 Scanty m. flow, with heaviness, languor, drowsiness, and
 albuminous urine. Helon.
 M.: flow black, of putrid odor, in clots. Am-c., Croc.,
 Cycl., Ign., Plat.
 M.: blood black as ink. Croc., Cycl., Kali-n., Nitr.,
 Sabin.
 M.: discharge glutinous, thick, acrid, black, pitch-like.
 Magn-c.
 M.: flow pale. Mancin.
 Pain in the mammæ at every period, as if they would
 ulcerate. Merc.
 M.: blood thin and black; lumpy, black or brown fluid,
 and of disgusting smell. Sec.
 M.: disorders, with intense cerebral congestion. Bell.,
 Ver-v.
 M.: colic preceded by great congestion and troublesome
 strangury; plethoric women. Ver-v.

Bearing pain in the left ovarian region, better from pressure, but entirely relieved only during m. flow. Zinc.

MENSTRUATE.

On second day after time to m., cutting in bowels, limbs clammy; followed by profuse bright yellow leucorrhœa, excoriating the perineum. Lil-tig.

During the effort to m., she is so weak that she is scarcely able to stand. Cocc.

MENSTRUATION.

Painful m. Ars., Bell., Cact.

Painful m., causing loud cries. Cact.

Very profuse m. Can-ind.

Vicarious m. Bry., Ham., Puls.

Intermittent m. Hyos.

Excessive m. of bright red blood. Kali-c.

Premature and profuse m. Calc-c., Senecio.

Retarded and scanty m. Sep., Senecio.

Sterility, with too early and too profuse m. Sulph.

M.: with constrictive spasms of uterus; pains agonizing, worse at evening; flow scanty, ceases when lying down. Cact.

EXPLANATORY NOTE BY THE AUTHOR.

In compiling and arranging the symptoms in the Concordance Repertory, the following rules have been observed :

First. Select and give all of the more characteristic pathogenetic symptoms.

Second. Include only such clinical symptoms as have been repeatedly verified.

Third. Where two or more remedies have the power of producing a similar condition, include them, as merely suggestive, under the name of the condition produced.

Fourth. Give the word conveying the central thought or object of the sentence, also the verbs and essential adjectives.

By this arrangement all symptoms, entire, are brought together under each, conditions and concomitants, and the same symptoms are given again under the rubric of conditions and concomitants, so that, like a map, all symptoms, conditions, and concomitants are brought at once before the eye and mind of the physician. As above, all symptoms in which the word "menses" occurs are brought before the eye. If this was all, the Concordance Repertory would not be better than any other repertory. But it does more. For instance, the physician is called upon to prescribe for a patient who complains of having "cholera-like symptoms at the commencement of the menses." The physician has no time to read all the symptoms under the heading "menses" to find the desired symptom. With the Concordance Repertory, all he has to do is to turn to the heading "cholera-like," and quickly finds the desired symptom and all other symptoms bearing upon his case. It will be noticed that many "menses" symptoms are distinguished by having "pain in back." The prescriber can in a moment find these under "back." "Menses too early, too profuse, with pain in the back." This symptom may be found in E's, under "early" (where it is associated and compared with all other symptoms in which the word "early" may be found); in P's, under "profuse" (where it is associated and compared with all other symptoms in which "profuse" is found); and in B's, under "back" (where it is associated and compared with all other "back" symptoms). So that, in enabling the physician to quickly find a symptom, it brings under his eye at once all the symptoms in the *materia medica* bearing not only upon any given subject, but upon all subjects suggested by a word in any sentence or symptom under consideration.

WILLIAM D. GENTRY.

KANSAS CITY, MO., April, 1889.

STRICTURE OF THE RECTUM.

BY W. H. PIERSON, M. D., BROOKLYN.

I was called in the night of July 4, 1888, to Mrs. J—, 46 years of age; married to her present husband twenty-eight years; previously married, and, when about four and a half months pregnant, miscarried. Found my patient suffering from what I diagnosed to be a hystero-epileptic convulsion, and suffering agonizing pain in the rectum, radiating in all directions through the abdomen, about the back, and particularly down the anterior portion of the thighs. After obtaining a little intelligent history of the case, and among them the symptoms of stricture of the rectum, I prescribed for her immediate condition, and called the day following to examine her thoroughly. I would also state that her attention was first called to the stricture and pain in the rectum after recovering from an attack of entero-colitis in 1874, after which she was always more or less constipated. She had prescribed for her during her sickness massive doses of opium to check the excessive movements, and then, when constipated, large doses of calomel to relieve the constipation. This alternating condition continued for quite a length of time.

Through the posterior vaginal wall I came in contact with a mass, hard and resisting in character, filling the vagina so that I could not possibly reach the cervix with the finger, neither was it possible to introduce a small bivalve speculum sufficient enough to explore it. Examination per rectum revealed a constriction by actual measurement five and a half inches from the anal orifice, which would possibly admit a No. 18 American sound. Defecation was performed with great difficulty and pain, the feces never being larger than an ordinary lead-pencil and sometimes flattened, ribbon-like. I at once became suspicious that my patient was suffering from cancer of the rectum, basing my

opinion largely upon the existence of the mass and the fact that she was frequently passing bloody pus. The examination was necessarily painful, but she improved daily after it for a period of two weeks, the diameter of the fæces being larger and the pains considerably lessened. Again the pains increased with renewed vigor, so that morphia had to be resorted to, but there was no repetition of the convulsions. The stricture being located in the upper portion of the rectum, the introduction of bougies was painful, and when situated there retention was impossible, as she would involuntarily expel them; and as hemorrhoids complicated the case somewhat their presence caused excruciating pain.

I have termed the lesion "stricture," but there was something more than that, which was a succus or cul-de-sac surrounding the stricture, extending into the sub-mucous tissue, forming a receptacle for fecal accumulations in large quantities. That was the mass bulging the vaginal wall which on first examination caused me to think it was a growth. This also caused pressure on the sacral plexus, thus accounting for the neuralgic condition before described; relief being obtained when the feces were forced out of the little pockets and pressure relieved, and the stricture dilated so that it could escape. My method of dilating was not the one recommended in books. After repeated trials and as many failures with the bougies, I finally discarded them, and with a bivalve speculum and a pair of long-bladed forceps could, with comparative ease, stretch the stricture, this being more effectual and less painful than the bougies. The pain has entirely disappeared from the abdomen; the movements are of fairly good size and painless, although she had accustomed herself to the use of cathartics. I am frequently obliged to give her a laxative pill composed of ext. colocynth 3i, ext. nux vomica gtt. xx, ext. belladonna gr. x, made into xxx pills. This increases the peristaltic action, producing a satisfactory

evacuation. This is resorted to about once a week on an average. She has been receiving medicine all the time, most benefit being derived from *Nux vom.*, *Æsculus, Ars.*, *Coloc.*, and *Aloes*.

If I may be allowed to quote a few authorities on the subject, Dr. Thomas Morton of the Pennsylvania Hospital recommends two modes of treatment for the non-malignant stricture—dilatation and linear incision (rectomy), dilatation by the finger alone, or by the finger covered with rubber covers of various sizes, that are open at the end so that the sense of touch is left to the end of the finger. This is, of course when the stricture is within reach. When the stricture is out of reach, either the gum or metallic bougies can be used, beginning with the smaller sizes, gradually using the larger ones, until the desired dilatation is obtained. When the lumen of the stricture is tortuous it is best to use a long, slightly flexible rubber bougie having an olive-shaped extremity. With these it is not advisable to leave them standing except for a short time, as it is liable to excite inflammation of the rectum. If the stricture is irritable, every second or third day would be sufficiently often to attempt dilatation. In constrictions which are firm and not too sensitive he inserts a Molesworth elastic tube, and gradually distends it by hydrostatic pressure, or the Barnes dilater has been equally successful. When the stricture is inelastic and reforms itself immediately after dilatation, incisions should be practiced. When located low down, the constriction may be nicked in several places with a hernia knife, the blade of which is guided along the finger in the bowel. When higher up, a double-bladed knife must be used.

When the stricture is of syphilitic origin, in addition to dilatation medication is indispensable. Morton also describes an uncommon disease as dilatation of the rectal pouch, or Physic's encysted rectum, which is an hypertrophy and sometimes an inflammation of the rectal sac; this

condition being caused by the lodgment of extraneous substances, such as indurated fecal matter, seeds of fruit, and other undigested masses. Constipation also predisposes to this affection, as the bowel is kept distended with hardened feces. This disease is insidious, but is capable of producing intense suffering should inflammation, suppuration, or ulceration attack them. The pain, which is aching burning in character, is not confined to the part affected, but radiates down the thighs toward the back and through the abdomen, being identical with the pain described by my patient. Van Buren advises, in the use of bougies, that their regular and systematic employment is necessary to secure its best effects; but if it cannot be tolerated, recourse to other treatment is necessary.

One point of practice has been established by his experience, and that is, that it is inadmissible under any circumstances to employ force in the introduction of a bougie, and that the bowel has been fatally perforated in the process of exploration for stricture. He also claims the bougie as a remedy for stricture is over-estimated; however, in thin-edged, valvular, congenital stricture, when the mucous membrane of the gut alone is involved, we have good evidences that it has aided in effecting radical cures; but in tubular, fibrous, or cicatricial strictures the knife must be resorted to. In dense and tight strictures, with a view more to immediate relief than a slender bougie could offer, a sponge tent or a strip of laminaria has been used for rapid dilatation as a preliminary to the ordinary bougie; but the force required for their removal after swelling, and the possibility of laceration attending it, are counterbalancing disadvantages. The same objection to Molesworth's tube and the Barnes dilater is apparent in consequence of the difficulty in measuring the force applied. Perhaps the Allen pump may here fill a vacancy, as with this instrument the force used can be accurately measured. It has been claimed that stricture of the rectum as well as the urethra may be

cured by electrolysis, and the dissolving power brought to bear upon the disease, but as yet in few instances and without positive results. To Dr. George Murray Humphrey of Addenbrooke Hospital, England, belongs the credit of introducing the complete longitudinal division for stricture; the section comprising the whole thickness of the rectum below it and including the two sphincters. The wound then made includes a small portion of the rectal wall above the stricture, and, gradually growing deeper as it extends downward, presents its broadest portion below. The object of the completeness of the section here proposed is to remove at once in the freest manner all obstruction to the action of the bowels, and at the same time radically cure the stricture by its thorough longitudinal section in accordance with the principle first fully established by Reybard for the urethra. In the case narrated the patient positively objected to all cutting operation, although the stretching process was experimental. The results obtained are very satisfactory. She is now able to go about and attend to her housework, with very little, if any, discomfort with the rectum.

THE THIRD STAGE OF LABOR.

BY E. D. AYRES, M.D., LITTLE ROCK, ARK.

My experience as an accoucheur has fortunately been rather an even and uneventful one. I have not had any abnormal presentations since the breech has been classified as normal.

Of late I have practiced pressure of the fundus in second stage toward its merging into the third, and have been impressed with its advantages in hastening the delivery, and perchance, by continuing the pressure until some moments after the expulsion of the placenta, its aid in prevention of post-partum hemorrhage. I teach my nurses how to make

this pressure and with both hands well spread out, the force of the pressure principally upon center of fundus. The pressure is relaxed during the intervals between the pains, gradually increased up to the acme of the pain, and gradually relaxed during its subsidence. During the third stage, so soon as the perineum has become prominent from the descending head, the pressure is reduced to a minimum, becoming a bare support or backing to the natural contraction of the uterus. This is in order to give time for gradual expansion or stretching of perineum, to avoid its laceration. We never have a labor without apprehension on this score, although I am numbered among those who say they have never encountered this accident in their own experience. Shoulders have seldom caused delay or trouble after delivery of the head, and then a little patience is all that has been taxed.

This gentle support of fundus is continued until a pain for the expulsion of the placenta comes on. It is then increased to a pressure until some moments after expulsion of placenta, and until time has been allowed to demonstrate freedom from hemorrhage.

Post-partum hemorrhage has occurred in my practice in any degree of severity but a few times, and then has been instantly relieved by the introduction of the hand into the uterus, the other hand upon the abdomen, and pressure between the two to incite contraction. We are aware that cases have occurred to others in which, this procedure having failed, resort has been had to injections of acetic acid, iodine, hot water, etc., and we believe the consensus of opinion is in favor of this latter in quantity, and with persistence of duration. We incline to the belief that this immunity from this fearful complication is due in part to this system of pressure upon the uterus, and also largely to the exhibition of the indicated remedy all through the labor.

Nowhere in all the field of medicine do we believe the

superiority of homœopathy to be more clearly demonstrated than in obstetrical practice. After-pains, the great bugbear of allopathy, is so largely prevented by the exhibition of arnica, occasionally alternated with aconite, as to astonish the nurses and laymen who witness its use for the first time. When the after-pains are severe, behold the prompt and sure relief from actea or caulophyllon, or any other indicated remedy, as in case of large and numerous clots, the brilliant result from sabina. So all the way through, in cases, for instance, where pains, although severe, are yet not entirely periodical, but continuous, with no presentation, in fact with no dilatation, but the os rigid, showing the pains to be due to contraction of the circular fibers; so, too, when pains are weak and inefficient, or so acute as not to be borne, the indicated remedy rights up matters and hastens on a speedy and satisfactory result.

As to the question of choice between attention to mother or infant where post-partum hemorrhage and asphyxia of the child are coincident: it would take but a moment to direct the application to the child of Marshall Hall's "ready method modified by later improvement," this to be continued by an attendant until such time as attention to the mother could be omitted for a moment, and so both pursued simultaneously. The mother demands the best service because the result is sooner to be determined, and we have seen a child draw its first breath after twenty-five minutes had elapsed.

Appropriate medication should by no means be neglected after the cessation of the "flooding," lest a secondary flow set in.

As to the use of chloral hydrate where pains are annoying and no progress made, or of morphine for the same purpose, we would state that we have in no single case resorted to any such expedient since in 1860 we adopted the practice of homœopathy, but have faithfully, confidently and successfully combated all untoward symptoms and

events with the "similimum." Previous to that date, as an allopath we had used morphia sulphate to allay false pains, and to soften and dilate the os and cervix, with the result of witnessing, after a brief lull, the approach of regular pains, which proceeded with unwonted vigor and celerity to the consummation—the birth, precisely as we have seen the speediest delivery follow the checking of puerperal convulsions by the inhalation of chloroform. This, too, we have not needed since practicing homœopathy.

TUBO-OVARIAN DISEASE *VERSUS* PELVIC CELLULITIS.

BY R. LUDIAM, M.D.

Extracts from a clinical lecture in the post-graduate course in the Hahnemann Hospital of Chicago.

Of the three laparotomies which the different members of the post-graduate class have seen me make within the last ten days, one was for the removal of a parovarian cyst weighing twenty-one pounds, and the others for the extirpation of the ovaries and tubes in old intractable pelvic disorders. I am glad to say that the patients have all gotten well and returned home.

The last two of these cases deserve more than a passing notice, and suggest the propriety of discussing the clinical history of diseases of the fallopian tubes and of the ovaries in connection with that of pelvic cellulitis and abscess. The first one was brought hither by Mrs. Dr. M. A. Kester, of Topeka, Kansas, with the following history:

Miss Dr. —, æt. 31, began menstruating at seventeen years of age. From the first she suffered with membranous dysmenorrhœa. In April, 1887, she was thrown violently across the dash of her buggy, striking the lower part of the abdomen on the sharp corner of the dash. The following June she was ill all the month with severe pain in

the left ovarian region, and more or less fever and general malaise. She dreaded to go to bed at night for fear that she would not be able to leave it in the morning. July 3, she was taken with an intense pain just over the pubic bone, while in her office; so severe was it that she was unable to stand long enough to telephone for help. Some friends found her an hour or two later and took her home with them. The pain became unbearable, and chloroform was resorted to. In a few days an abscess pointed and broke on the right labium externally, discharging a large quantity of offensive pus. Although the weather was very warm, she complained all the time of being very cold, and had to be wrapped in blankets with hot-water bags around her. A peculiarity of her suffering was that her flesh and even the bones felt as if bruised or crushed, and she would ask her friends to raise her hand, so that she could be sure that it was not really crushed. All the time there was copious hemorrhage. I saw her about the middle of July. She then talked of going home to her family in Detroit. I found the soft parts swollen, hot, tender, and a decided bulge on the left side of the uterus, well up in the roof of the vagina. A week later she started for Detroit, being carried from her bed to the berth in the sleeper.

There she was again seized with terrible pain in the left ovarian region, accompanied with violent vomiting, which kept up at intervals of ten minutes for seventy-two hours. A peculiar symptom developed at this time; if she turned her head to the right it caused violent sneezing or vomiting, which aggravated the pain and the hemorrhage. She was treated homœopathically, and by Sept. 1 was back in her office, but was still very sore and tender.

About Nov. 25, 1887, she was again seized with intense pain which continued three days, when there was a profuse discharge of pus and blood per vaginam. This gave some relief, and she started out to make her professional calls, but fainted at the first house and was taken to the home of a

friend, where the experience of the preceding summer was repeated. Terrible pain, coming on every afternoon, last-



FIG. 1. THE OVARY, THE TUBE, AND THE Pus-Pouch.

ing from one to four hours, with hemorrhage and discharge of pus. There was at this time an opening on the inside of each labium and one in the roof of the vagina. She was

unable to resume practice until Feb. 1888. In Dec. 1888, she again commenced flowing profusely, and continued to more or less until the operation March 3, 1889. I was again called, Feb. 1, and found that the old trouble had returned. Her pain was intense, coming on every afternoon and continuing from two to three hours. This had already been repeated for six days. I advised an operation and urged her to go to Chicago.



FIG. 2. THE RIGHT OVARY AND TUBE.

The additional facts are that she has never passed a monthly period without the most atrocious suffering for twelve hours or more, and that in all she has had four abscesses, three of which have discharged from the left and one from the right side.

The operation was made March 3, at which time both of the ovaries and both of the tubes were removed. The left ovary was not so large as the right one, but its tube had developed into a large pouch, which was bound to the ovary

by very firm adhesions, while its fimbriated extremity had formed a pūs-sac that would hold about two ounces. (Fig. 1.) The right ovary was six times the natural size, and cirrhotic like its fellow, while the corresponding oviduct was very much thickened and enlarged in its outer two-thirds. (Fig. 2.) The evidences of previous peritoneal inflammation were especially pronounced in the left side of the pelvis. There were no signs of pus in the peritoneal cavity.

The other patient was sent to the hospital from Tennessee. A Mrs. M., æt. 28, was admitted Feb. 12, 1889. She was married at 17, since which time she has always been ill. She has been treated for various diseases, as gravel, uterine displacement, nervous prostration, dysmenorrhœa, rheumatism in the shoulders and arms, pain in the ovarian region, and for dyspepsia for weeks together. She has also been told that her lungs are weak, that she has "bronchial trouble" with much sore throat. She has never been pregnant. Local examination finds the uterus acutely anteфлекed, and the vaginal cervix extremely tender and sensitive. The os-uteri is slightly torn in consequence of the forcible dilatation that was practiced for the relief of the dysmenorrhœa.

Feb. 20, during menstruation, she passed an almost complete cast of the uterus, which cast is very thin and diaphanous, the result of an exfoliative endometritis. This was accompanied with the usual severe monthly suffering and with extreme nervousness, bordering on hysterical spasms, to which she has been subject under these circumstances. The menstrual flow is free, but not long continued, and is sometimes followed by a discharge of pus. The pain is chiefly in the ovarian and inguinal regions, and is evidently due to a relapsing peritonitis.

Feb. 27 she was examined in the clinic, and, although an accurate diagnosis could not be made out, it was decided that, in all probability, there was disease of one or both the fallopian tubes and possibly of the ovaries also. An explorative laparotomy was accordingly advised.

In this case the operation was made in this amphitheater yesterday morning, March 15. You remember that it was begun as an explorative expedient, for a double purpose, (1) to reach an absolute diagnosis, and (2), in case it became necessary, to remove the ovaries, or the tubes, or both and all of them. The steps of the operation are fresh in your minds, and also the fact that while I found the left ovary and its tube to be healthy and normal, the right one was diseased, and had to be taken away. This proved to be the



FIG. 3. SACCULATED TUBE AND OVARY.

seat of the mischief, for it was a case of pyosalpinx in which the tube had become sacculated, each compartment being a pus-pouch, and all of them having an exit through its inner extremity into the uterine cavity. (Fig. 3.)

In 1856 my old teacher, Bernutz, of the Hôpital de la Charité, in Paris, made the first careful dissection of several cases of pelvic peritonitis, named the disease, and published an accurate diagnosis between it and the only form of pelvic cellulitis which he could identify, and which he thought

fit to recognize, viz., abscess of the broad ligament. In all of them he found there was present the most decided evidence of disease of the ovaries and of the tubes, and with his keen clinical insight determined that intra-peritoneal abscesses were due to the conveyance of infectious material through or by the tubes to the ovary, inducing the feminine orchitis, or into the peritoneal cavity, where plastic inflammation was set up and circumscribed abscesses were formed.

For almost thirty years this remarkable discovery failed to be understood and appreciated. It is only since the resort to tubo-ovariotomy, and to the expedient of explorative laparotomy in chronic and forlorn cases of pelvic disease, that it has been verified and put to a practical use. In no other direction have the results of peritoneal surgery been more surprising or more satisfactory. . . .

It is generally conceded that peri-uterine cellulitis is rare in the case of women who have never conceived, and yet the occurrence of peritoneal abscess in this class of patients is by no means infrequent.

Child-bearing often gives exemption from dysmenorrhœa, while it greatly increases the risk of what is usually called pelvic cellulitis. Some of the worst cases of painful menstruation that we meet with are associated with the periodical discharge of pus through natural or unnatural outlets. If dysmenorrhœal suppuration is common among the unmarried and sterile, and peri-uterine abscess is not so, there can be no necessary connection between the formation of pus and the occurrence of inflammation of the pelvic areolar tissue. Manifestly, we may have one without the other, and our old notions of the clinical history of these lesions must be modified. . . .

But how can pelvic peritonitis give rise to the symptoms of cellulitis and result in the formation of abscess, whether in puerperal or non-puerperal women? In the former, by the extension of the puerperal mischief from the uterine cavity along the oviduct to the ovary, and to the perito-

neum ; in the latter, by a similar transfer of gonorrhœal, catarrhal, or of other infectious material in the form of pus, or mucus, or of decomposed blood along the same channel, and to the same point. Arrived there, the septic or pyæmic accumulation is discharged into the peritoneum, where it excites such a degree of adhesive inflammation that it is soon imprisoned by false membranes, and kept from killing the patient through an attack of general peritonitis. When this pouch has been formed, its contents must find a means of escape, or an outlet through the bottom or sides of the pocket into the rectum, the vagina, the bladder, or, as in one of the cases just cited, along the side of the vagina and through the labia majora.

The varying site of these secondary abscesses is easily explained. The tube and its corresponding ovary may drift away from their natural position and become anchored in the Douglas pouch, in front of the uterus, low in the pelvis, or high in the abdomen. Wherever they may happen to be, the morbid process that we have indicated may go on, and when an abscess has formed we usually refer it to cellular inflammation, when the whole mischief is intra-peritoneal, and, unless it perforates the peritoneum and points externally, has nothing to do with the areolar tissue. . . .

It is this kind of peritonitis, with its propensity to form false membranes, that sometimes glues the intestines, or a portion of the omentum, with the fallopian tube and the ovary, into a mass that is easily mistaken for a tumor. Sometimes this mass is adherent to the abdominal wall in the iliac region, or over the bladder, in front of the rectum, and above the vaginal roof, where, especially if there is any discharge of pus or evidence of suppuration, the supposition is that the case is one of peri-uterine cellulitis. In the last twenty-five years I have shown many such cases in this clinic, where I have convinced myself and a host of pupils that the lesion was undoubtedly due to pelvic cellulitis. We had no proof to the contrary. When we had gotten on

far enough to tap some of them by aspiration, a great point was gained, for the result was confirmatory and the recovery was hastened. Nobody had dared to cut down upon such a formation in the living subject, and our diagnosis was sometimes "a lame and impotent conclusion."

But now we know better. Thanks to the progress of gynæcological surgery, and to its practical confirmation of the views of Bernutz, the way is literally open for a better diagnosis and for more skillful and satisfactory treatment in these and kindred cases. Where there is doubt, and nothing else will bring relief, we can cut down upon a plaque or *plastron* of this sort, and if the bowels or the omentum are soldered together and to the abdominal parietes, in consequence of a benign peritonitis, we can separate them, turn them aside carefully, and find the diseased tube or the ovary, or both, or the abscess if there is one, and excise the one or drain the other, and so dispose of the whole difficulty. . . .

A practical reason for differentiating between an abscess from exudation into the pelvic connective tissue and pyosalpinx, or ovarian abscess with peritonitis, whenever it is possible, is that their proper surgical treatment is very different. For while aspiration would be the right thing in the former case, it might be very harmful in the latter. It is only when the abscess is very low down and adherent to the vagina, that an opening by the needle or the knife should be indiscriminately made.

But suppose that, instead of removing this tube (Fig. 1) with its enormous pus-pouch and its demoralized tunics, I had tapped it with the aspirator-trocar? Do you not see that, while we should have obtained a small quantity of pus, the failure of the tissues to contract on the withdrawal of the needle would have involved the risk of purulent infection? Even if our patient had escaped such a mishap, is it not evident that the diagnosis would still have been imperfect, and she as badly off as before? And what of

the other ovary, with its scar from the rupture of an old abscess and its distended tube? (Fig. 2.)

Or, if we take this sacculated tube (Fig. 3), what could we have learned or accomplished by aspirating either of its compartments through about two inches of adipose in the abdominal wall?

There is another phase of this subject that has great



FIG. 4. HÆMATO-SALPINX.

clinical significance. It is not unusual for physicians to direct their treatment to endometritis, to some form of uterine deviation, or to menorrhagia, as if they were always primitive affections; when they may depend upon peri-uterine inflammation and abscess. Our two cases illustrate this fact, and I could adduce many more of a similar kind. There is quite a share of cases of chronic endometritis, with

or without any menstrual moulting, and disconnected with uterine sub-involution, that are secondary upon disease of the ovaries and tubes and a coincident peritonitis, and which can only be cured by getting at the root of the difficulty. We might have treated the case from which this sacculated tube with its multiple pus cavities was taken, until doomsday, for her uterine flexion, without curing the dysmenorrhœa and the chronic invalidism.

Here is a specimen (Fig. 4) that I removed from a patient of Dr. Coutant, of La Salle, for the relief of an intractable menorrhagia. It was a case of hæmato-salpinx of one of the tubes—the other being healthy—and you can readily understand why the doctor's well-chosen remedies failed to cure the hemorrhage, and why the curette within the uterine cavity could not have accomplished any better result. But now that this diseased and offending member is disposed of, like a decayed tooth, the woman is all right again.

In the case of a woman aged thirty-four, a patient of Dr. E. Z. Cole, of Michigan City, and upon whom I operated three weeks ago for the relief of a relapsing peritonitis, violent dysmenorrhœa, and sterility, recovery has followed promptly. One ovary was left, and she has since menstruated for the first time in many months without the slightest pain or discomfort. Here is the offending ovary and tube, with an enlarged hydatid of Morgagni (Fig. 5). . . .

The fact that it is possible to shell out and to separate these diseased organs by gently tearing away the false membranes which surround them proves that their adventitious capsule is not formed of cellular tissue. If they were located in the connective tissue that intervenes between the layers of the broad ligament, where they would be outside of the peritoneum, it would be impossible to remove them without leaving a diseased structure or suppurating surface behind. . . .

I have spoken of but one of the routes by which infec-

tious matters may penetrate the intra-pelvic tissues. It is not the only one, but in non-puerperal cases it certainly is the most natural and the most important one. And in some of the secondary affections of childbed also the oviduct is the channel through which the noxious material is drained from the uterine into the peritoneal cavity. This is notably so in puerperal peritonitis when it occurs after the first week of the lying-in, and hence the significance of a relapsing tubo-ovarian peritonitis that dates from labor,



FIG. 5. OVARY, TUBE, AND ENLARGED HYDATID OF MORGAGNI.

no matter how long an interval may have elapsed since the child was born.

Doubtless the uterine lymphatics afford a means of transit for septic materials from the cervical and the vaginal mucous membrane to the areolar tissue within the pelvis. This is the explanation of abscess within the broad ligament when it follows a traumatism of the soft parts, the use of unclean instruments, or dressings, and the lack of antiseptic precautions in labor, or in the performance and

the after-treatment of the minor gynæcological operations. But we must not forget that the peritoneum itself is an expansion of lymphatics, and that in case of infection from the placental site, or from a lacerated cervix, or vagina, or vulva, it would be less likely to escape than the cellular tissue, even if the latter were more abundant than it really is about the neck and the sides of the womb.

It may happen that an abscess of the broad ligament shall follow the rupture of an over-distended tube in pyosalpinx. Here the discharge, coming from a break in the lowest and weakest portion of the tube, would be turned directly into the cellular tissue lying within the broad ligament, and consequently we might have to treat a double abscess that would tax our surgical skill very severely.

In calling your attention to this subject my desire was not to throw doubt upon the existence of pelvic cellulitis, but to show that, in the light of recent investigation and of increased experience in peritoneal surgery, we are forced to believe that many cases which were formerly thought to be of that kind should properly be referred to tubo-ovarian disease with an accompanying peritonitis.

THE INSANITY OF PREGNANCY.

BY H. H. CRIPPEN, M.D., SAN DIEGO, CAL.

(Continued from page 182.)

PATHOLOGY.—It is often disheartening in a post-mortem examination to fail in finding changes in the nerve tissues or cells by which we may trace the course of the disease. The insignificant changes in the increase or diminution of blood-pressure within the cranium, and the alterations in the nerve cells and their environs, are, many times, beyond our appreciation. But there are certain coarse lesions in the nerve tissues of the cerebrum, and in the surroundings

of these tissues, that I shall first mention, reserving quantitative changes in the blood-supply to the cranial contents, and its dependency upon reflex causes, for later discussion.

First, as to coarse lesions. Hammond* and Voisin† express the opinion that the "patho-anatomical feature is quite surely congestion in that form which immediately succeeds childbirth." That "in those cases of the disease in question which occur during or soon after the termination of nursing, an anæmic state of the brain is discovered. But, when ensuing on the sudden cessation of lactation, the symptoms indicate cerebral hyperæmia; and such is the state found on post-mortem examination." Gooch gives two cases of post-mortem, in one of which "the veins throughout the body were remarkably empty, the heart contained little blood, the lungs and liver were singularly pale. Within the head there was the same deficiency of blood in the veins of the pia mater, and in the sinuses under the arachnoid was a little serum. On slicing off the hemispheres the bloody points were unusually numerous." In the other case, "the body was examined eleven hours after death. In the abdomen the viscera were healthy, the peritoneum also; the external and internal surface of the uterus, as also its substance, were examined and found natural. There was about half a pint of reddish fluid in the peritoneum. In the head the sinuses were thought to be rather more loaded than natural, the dura and pia mater rather thicker than usual; there was no unusual effusion anywhere. The plexus choroides appeared unusually pale; the substance of the brain was firm, and on slicing it no bloody points appeared."

I am fortunate in being able to present the history of a case in which a post-mortem examination was made. Mrs. A. W., age 23, has an uncle insane. She is a person of previous good health, except an attack of insanity

* "Treatise on Insanity," 1883.

† "Leçons Cliniques sur les Maladies Mentales," 1883.

four years ago, lasting five months. The present attack dates from one week after parturition. Her confinement was easy and natural; the child is living and healthy. She first became restless and sleepless and talked in an incoherent manner. This condition grew worse until her friends decided to place her in the hospital. At the time of admission she was in a very weak condition with violent and excited manner. For the first three days she was very violent so that it was necessary to place her in a padded room. On the fifth day she began to grow weaker in spite of liquid nourishment, and gradually sank until the seventh day, when she grew rapidly worse and died.

Post-mortem 24 hours after death : Body well nourished ; rigor mortis present, not augmented. Head ; calvarium normal, vessels on surface of brain gorged with blood. The arachnoid and pia mater are rather adherent and on peeling off leave a rough surface of gray matter. Brain of good consistence and gray matter of full depth. Weight of encephalon 47 oz. Cerebellum, cerebrum, pons, and medulla, all quite natural. The remaining organs, the thoracic and abdominal are perfectly normal. The uterus is large and presents the usual appearance of subinvolution. The evidences, in this case, of congestion, with some inflammation of the meninges, are plainly marked.

In a case of religious mania, occurring at the third attack of insanity during pregnancy, Voisin mentions the existence of *punctæ vasculasæ*, small points of blood dotting the surface of the brain, which I have often seen in other forms of mania, and of, "a hyperæmic state of the optic thalami and of all the central portions of the cerebrum. The parietal convolutions exhibited in the perivascular sheaths of their vessels numerous masses of fat-molecules and pigment. Like aggregations were found in the optic thalami."

Such are the very obscure conditions found after death in cases of insanity of pregnancy, and we must confess that, as yet, nothing positive can be predicted as to the relation of

mental symptoms to pathological changes in the cerebral economy.

There yet remains the question of the mode of origin of the mental unsoundness during pregnancy, parturition, or lactation; that is to say, why, and in what manner, can the changes taking place in the sexual organs of women reflexly produce insanity? This is certainly a pathological question of great importance, and will be found to involve the principles I have dwelt upon in a previous work.*

Certain preliminaries are necessary to a proper appreciation of this question, and even at the risk of some repetition I must take up the explanation of the effect of morbid sympathetic action. Briefly speaking, we have in anatomical and in functional relationship three factors upon which depends the preservation of the proper adjustment of reflex tissue impressions. These three factors are the afferent and the efferent nerve fibers of the sympathetic system and the ganglionic cells through which they attain, by intercommunication, influence over the vascular supply of every part of the body.

The afferent fibers, centripetal in function, form in the genital tract of woman a large part of the bulk of what have been named the sensori-motor nerves. They do not primarily influence the vascular system, for they hold no direct relation to the muscular fibrillæ of the coats of the blood-vessels, but they may reflexly influence the vascular supply of any part, however distant, by their communications with the efferent fibers through the caudate cells of the ganglia which they enter. As to the latter, the efferent fibres of the sympathetic, it is sufficient to say that they proceed from the central ganglia to their destination on the coats of the arteries, and are centrifugal in function, conveying impressions to the vascular factors, thus regulat-

* "On the Relation of the Sympathetic Nervous System to Reflex Insanity; and especially to Insanity Secondary to Lesions of the Female Genitalia."—*The Homœopathic Journal of Obstetrics*, vol. 9, No. 5, p. 408.

ing the blood-supply of the tissues. From this it may be seen that the blood-supply of one part of the body may be subjected to influences proceeding from any other part, however distant or different in function the latter may be; the influences reaching the arteries in a reflex manner by means of the central nervous system; the afferent impulses being, for the most part, carried by sensori-motor nerves; while the efferent impulses pass along special vaso-motor nerves.

Hence we have in functional relationship the centripetal and the centrifugal nerve tracts and the ganglia through which these two tracts find intercommunication, and, as I have said,* "By means of these the elements of the organism are in a position of correlation through a reflex dependency of tissue impressions, which influence nutrition by vaso-motor action, and are in turn reacted upon by this same modification of blood-supply.

"Through this it becomes apparent that we have an elucidation of those vague morbid processes, formerly attributed to 'a sympathy or consent of parts.' For example, through the correlation of tissue tracts extensive burns have been followed by duodenal ulceration."

"It follows, then, that the function of the sympathetic is that of an organic mechanism, which in normal condition is capable of maintaining the tissues in proper relation to the whole system, to each other, and to external nature; but which, through disturbances in the equilibrium of its correlating function, becomes effective in producing modifications in separate and distant parts of the organism."

It is not difficult to harmonize the pathology of reflex insanity with the data I have given. It is only necessary to consider the fact that the healthy working of the mind depends upon the nutritive life of the brain cells, and then it will be clearly seen that normal brain force becomes directly

* Op. cit., p. 410.

dependent upon a proper nutritive assimilation of suitable material from the blood by the nerve cell, and that to modifications of this nutrition, due to vaso-motor disturbances, may be traced the initiatory process of reflex insanity.

From this, we will have little difficulty in harmonizing the pathology of insanity with the data of those cases that arise by reflex irritation. Especially will this apply to those cases secondary to changes taking place in the female pelvic organs; the well-known rich supply of nerves from the ganglionic nervous system at once impresses upon us the mode of origin of insanity and allied neuroses in over-excitement of the vaso-motors. In such cases it will be found, in tracing the impressions passing from the genital tract to the cerebrum, that the peripheral stimuli affect the end organs of the afferent nerves of the sympathetic, thence these impressions are conveyed to the ganglion in which the centripetal nerves communicate with other vaso-motor nerves (centrifugal in function) and finally our primary impression becomes reflexly manifest in modifications of nutrition within such areas of cerebral vascular supply as are governed by a ganglionic center of weakened resistance.

Of this weakened resistance we must now speak, for upon a basis of lessened resistance we may explain personal idiosyncrasies in the direction of mental aberration occurring during pregnancy, parturition, or lactation, and here what I have said before will still apply, that is: *

"Following out our theory of the initiation of disease through modifications of nutrition, we must put the determination of idiosyncrasy in this particular case upon a basis of the manifestation of disease in the part of least resistance, and, further than this, must consider such a part as dependent for its existence upon hereditary or acquired states of the system. Susceptibility to any entity of reflex mental derangement must, then, depend upon a lessened

* *Op. cit.*, p. 414.

resistance to reflex impressions on the part of those ganglionic centers that control the vascular mechanism of the brain." So that in all such cases of reflex insanity we have to deal with a deterioration of that part of the sympathetic system which presides over the nutritive life of the brain ; and this loss of resistance on the part of the sympathetic depends in many cases upon a hereditary depreciation, with, it may be, a superadded acquired neurotic tendency, or it can be dependent upon the latter alone.

" This is not to intimate, however, that the direct progenitors of neuropathic children may have been necessarily neurotic in tendency. Nor do I preclude this inference. Our knowledge of diatheses is too vague to predicate anything certain. The shading off of inherited syphilis, climatic, and food influences, etc., into a neuropathic diathesis is many times difficult to trace, but still there seems to be a certain display of the modifying effect of these various diatheses, in that they all institute constitutional conditions that are associated with a lessening of the resistance of the sympathetic ganglia, what Hutchinson * characterizes as a lack of nerve tone. Thus, he says, ' Perhaps it is further true that in most conditions in which derangement of tone is in question, the disturbance or enfeeblement has reference chiefly to that part of the nervous system which controls the circulation. Whenever the circulation is specially liable to reflex derangement, and congestions or their opposite occur with unusual facility, we are safe in declaring that the tone is low. It is part of the business of the nervous system to duly regulate the supply of blood to various parts, to prevent local arterial spasm, and under varying conditions of daily life to maintain the normal balance of circulation. When the power is deficient the various causes of disease act with greatly increased effect. In many cases loss of tone may be so long continued and

* " Pedigree of Disease."

so great that we can not but suspect that it depends upon degenerative and permanent changes in the nerve cells."

Thus it is especially in a neuropathic diathesis that the relative stability of the sympathetic nerve centers is lessened in power to resist irritation; becoming a condition in which the reflex impressions, arising from pregnancy, parturition, or lactation, flow beyond their natural channels, and find outlet in disturbance of the vascular factors of the brain, producing quantitative blood-changes, with consequent enfeeblement of the intellect, the perceptions, the emotions, and the will.

TREATMENT.—The first important consideration requiring our attention is the question, "Shall the treatment be at home or in an asylum?" The friends in many cases very naturally shrink from imposing the odium that socially falls upon a patient coming from an asylum. However, in later years, this opinion has been somewhat modified; the laity begin to understand that insanity is a disease as much as any other disorder, and that the sufferer is not to be treated as a criminal. Then, too, those prisons of years ago, where chains and manacles were employed in the treatment of lunatics, have given way to the better form of asylum, with rational treatment.

We may hope soon to see this obnoxious word "asylum" give way to "hospital"; for we have developed safely beyond the period of darkness; with rare exceptions, have even passed the epoch of restraint; and are entering upon changes which are necessary and imperative to secure the better treatment of cases of acute insanity. These changes present careful individualization of cases, the abolishment of the evils of the present asylums, the establishment of intermediate hospitals for the acute cases, and the gradual development of large asylums into homes for the incurable and chronic cases. Until this result shall have been accomplished we are dependent upon the material at hand.

Very few cases of puerperal insanity would require asylum

treatment if favorable conditions could be established at home. The decision depends to a great extent upon the means and ability of the friends to care for patient. If treated at home it is first necessary to surround the patient with such conditions as will secure safety. The patient must on no account be left to herself; she must be placed under the absolute control of a skilled nurse, who must of course act under the direction of the medical attendant. In cases acutely maniacal in character, this nurse must have, within call, sufficient assistance to control the violence of the patient.

The sanitary surroundings require careful attention, especially in those cases that are filthy in their habits.

The medical attendant should be skilled in the philosophy of the mind, in the anatomy and physiology of the brain and nervous system, and in medical science in general. According to the circumstances of the case he should be prepared to visit the patient several times a day at first, and in violent cases should be within easy reaching distance.

All these conditions involve great expense; but, if the friends can afford to fulfill them, the chances are much more in favor of the recovery of the patient than if treated in an asylum.

The remaining points to be considered include dietetics, hydrotherapy, and mechanical, moral, hygienic, and medicinal treatment.

Mechanical treatment involves the question of non-restraint, and herein lies the advantage of the intermediate hospital of which I have spoken. In the large grounds and gardens that should surround the hospital, the patient, attended by a nurse, has excellent opportunity for out-door occupation. In the Bethlem Royal Hospital, which is of the nature of an intermediate hospital, it is rarely necessary to restrain puerperal cases, and even when restraint is employed it is only in the nature of a padded room, with garments of strong cloth that the patient may not tear them;

the waistcoat, the restraint chair, straps, muffs, cribs, etc., have all been abandoned with decided benefit to the patients.

Concerning the question of "non-restraint" I desire to correct an erroneous impression given by Dr. William A. Hammond in his "Treatise on Insanity." Dr. Hammond says that Dr. Connolly, in 1839, demonstrated to the world the doctrine of "non-restraint," and that "Dr. Connolly enunciated a proposition . . . that 'any contrivance which diminishes the necessity for vigilance proves hurtful to the discipline of an asylum.'"

With all honor to Dr. Connolly for his eloquent words in defence of the "non-restraint system," and to his able demonstration of this doctrine at the Hanwell Asylum of London, we must dispute Dr. Hammond's statement that he originated the theory of treating insane patients without forcible restraint. In 1837, Robert Gardiner Hill, at that time Resident Medical Superintendent of the Lincoln Lunatic Asylum, England, expressed the belief "that it might be possible to conduct an institution for the insane without having recourse to the employment of any instruments of restraint whatever." * This system of treatment was adopted during that year (1837), and subsequently copied by others. We have further proof that Dr. Connolly was not the originator of the system of "non-restraint," in the fact that he acknowledges in his own report,† at the Hanwell Asylum in 1842, that he adopted this treatment from observations of Dr. Hill's plan.

Under mechanical treatment we must speak of forced feeding. The refusal of food has already been noted as a symptom deserving prompt attention. Persuasion may succeed in some cases; or if any fancy exist, such as a belief that food is poisoned and must be tested before partaking,

* "Non-Restraint System of Treatment in Lunacy." Thirteenth Report of the Lincoln Lunatic Asylum, 1837.

† Fourth Report of the Hanwell Asylum, 1842.

it is better to yield to the whims of the patient than to resort to force. When force is necessary the patient must be promptly and firmly secured, the mouth forced open by a mouth-gag, and a soft rubber tube, attached to a funnel, passed into the stomach, care being taken that it does not get into the larynx. At Bethlehem the favorite, when it is not necessary to use the stomach-pump, is a soft rubber tube introduced through the nostril. The food, in liquid form, may then be poured into the funnel, and readily passes into the stomach. One great objection to the use of the stomach-pump for forced feeding is that the valves get sticky and work badly.

In cases of great physical weakness enemas may be introduced into the rectum. Campbell Clark speaks highly of the value of defibrinated blood given in this way.

Dietetics in mental diseases may certainly exercise as great an effect as in other diseases. Theo. H. Kellogg has given an able exposition * of the value of careful regulation of the diet. Dividing insanity into states of mental exaltation, of depression, and of dementia, the most common forms occurring during pregnancy, during the puerperium or during lactation, we may, with great advantage, follow his directions.

(To be continued.)

LABOR WITH THE OCCIPUT SITUATED POSTERIORLY.†

BY T. GRISWOLD COMSTOCK, A.M., M.D., PH.D., ST. LOUIS.

A primipara, æt. twenty-four, in good health, was taken in labor at full term, Oct. 23, 1888, and attended by Prof. Goodman. Presentation recognized as the vertex, with

* "Dietetics in Mental Diseases," *Journal of Reconstructives*, Vol. II., No. 4, p. 8.

† Read before the Chicago Clinical Society.

normal pains, and the membranes rupturing spontaneously, early in labor. After the pains had continued some sixteen hours, the head well down below the brim, and no advance being made with each pain, Dr. Goodman applied the forceps, but without result, being unable to move the head. At this period of the labor, I was called in consultation, and found the head well down upon the perineum. The head seemed impacted, and was in no way influenced by the pains that were strong and vigorous, and I could not seem to move it by the touch, when made during the interval of a pain. The reason of this was, that the occiput was situated posteriorly. I then tried the forceps, but could not move the head, or bring it out of its position, so as to deliver it over the perineum. I then applied one blade of the forceps to the side of the head and tried to make rotation, but without effect. We then concluded to wait and see what nature would do. In the mean time the woman was becoming exhausted; the sounds of the foetal heart were very faint, and finally could not be heard. We then found that our only resort was to perform craniotomy and remove the child. With the approval of Dr. Goodman, I proceeded to make this operation, and with his assistance delivered her of a large-sized male child. The patient made a slow recovery, caused by the sufferings endured during the lingering labor, from the impacted head.

Mrs. W—, primipara, æt. sixteen, taken in labor Nov. 1, 1888, at full term, with strong pains, and a vertex presentation diagnosticated. The waters were evacuated early in labor after puncturing the membranes, and the pains continued to be very active for some twenty hours; attended by Dr. Bahrenburg, who, finding that there was no advance, applied the forceps, without favorable result. I was then sent for in consultation, and found the young woman suffering greatly and showing signs of exhaustion. Upon a careful examination, I found a posterior-occipital position, with head well down in the cavity of the pelvis, and already

pressing upon the perineum. I tried with the vectis to rectify the position, but found it impossible, as the forehead and occiput both seemed to be fixed immovable. I then tried by means of the straight forceps to deliver the head over the perineum, but failed. After waiting some time to see if nature alone would accomplish anything, and in the mean while the young woman becoming more and more exhausted, with no prospect of any favorable change, at the request of Dr. Bahrenburg I proceeded to make the operation of craniotomy, and safely delivered her of a large female child. The mother made a rapid recovery and was well in two weeks.

To have two such rare cases so near each other was most remarkable, as I had met with no such position in many years, where the occiput failed to rotate under the arch of the pubis before delivery. My first case happened fifteen years ago, when I attended a primipara, who had a lingering labor lasting over three days, as it was an occipito-posterior position, and with the assistance of Dr. Walker in consultation, we succeeded in delivering her with forceps of a dead child. She had a slow convalescence, but recovered, and was delivered by me some fifteen months later of a healthy living boy. The other was a premature child (seven months), and it was born alive, although the occiput was posteriorly situated, and it was so delivered. In this case I attributed the faulty position to a large-sized pelvis, and this was the reason that rotation did not take place, but from the large capacity of the pelvis the child was born alive. It is a sad report to make of four such cases, all but one fatal to the child; but I regard this peculiar position and failure of normal rotation as a matter of very great importance to the obstetrician, and we should be prepared to cope with such vicious positions when we meet with them in practice.

The best treatment we can recommend, is to make the diagnosis early in the labor, and then try and introduce the

whole hand and rotate the occiput forward. To do this successfully, the bag of waters should be preserved as long as possible, and we think it can be done better if the woman is in the knee-elbow position. In some cases of shoulder presentation I have succeeded in rectifying the position by keeping the woman upon her hands and knees, or reversed, that is, lying with the limbs up, so that the uterus may stand in a perpendicular position, with its cervix situated upward, and fundus downward. When the occiput lies posteriorly the posterior lip of the uterus is depressed and the anterior lip elevated; the occiput lying behind tends to depress the posterior lip below the anterior lip, so that the cervix will be found unusually low in the pelvis. As the vertex lies posteriorly in the hollow of the sacrum, the expulsive power of the uterus acts through the spine of the foetus, and the neck is curved so as to make an angle, and thus presents an obstruction, and when it is pushed out of the hollow of the sacrum it has to change direction and take an up-grade, when it meets with resistance at the perineum.

Remember the whole foetal ellipse is packed into the lower pelvis, and the uterus is empty, although still powerfully contracting, and can not act upon the foetus. To expel the foetus, with the occiput posteriorly pressing on the perineum, will require for its delivery that the mother shall herself powerfully bear down, and, by the aid of the forceps, we can elevate the head and produce flexion until the occiput has glided over the perineum; then extension is to be made, so that the sinciput may be released from its impacted position under symphysis, when complete delivery may be accomplished. When the head is pressing down upon the perineum, and meets with obstruction there, and is greatly endangering it, we would suggest that lateral cuts be made in the perineum, so as to relieve the obstruction, and assist in the delivery of the head; for at this period the distended perineum is a great bar to delivery, and the occiput can not glide over it without rupturing it. We have occasionally

made the operation of episiotomy in cases of normal position, where the perineum was unusually distended, and we were sure that the head could not be expelled without a rupture, and we have found it a most admirable resource.

This little operation, which has been called "the young practitioner's operation," we first learned in the obstetrical clinic at Vienna, under the direction of Prof. Braun, and to guard against a traumatic rupture of the perineum, it is emphatically an operation, if not of election, one of necessity, and in a few cases where we have had occasion to resort to it we have never regretted so doing. The lateral incisions usually heal spontaneously, much better than jagged lacerations made from long pressure of the foetal head.

Résumé. I. When the occiput does not rotate normally, and it is driven down into the cavity of the pelvis, it has to travel at least three times as far as when it is anteriorly situated.

II. In this vicious position the whole body of the child is jammed down into the cavity of the pelvis, and this is necessary before the occiput can escape over the perineum.

III. In this position, the occiput is at first forced a downward grade, into the hollow of the sacrum, and then, to further advance, it must take an up-grade in order to glide over the perineum.

IV. In posterior rotation, as I have stated, the occiput has to travel at least ten inches before reaching the outlet whereby it can escape into the world, and the whole foetal ellipse (which only measures eleven inches) becomes jammed down into the cavity of the pelvis, and then the uterine power for expulsion is lost, although the pains still continue, and exhaust the mother.

V. One of the most frequent accidents of delivery when the occiput rotates posteriorly, is if the head is delivered in this position, that the perineum is ruptured.

VI. When such cases occur, and we cannot deliver with the forceps, I would propose that lateral sections of the

perineum be made (episiotomy), and then the delivery can be accomplished. After such a proceeding, I should advise that the lateral cuts be closed at once by catgut sutures. Experience has proved that such wounds made by the knife will heal much easier than jagged wounds made in the central line by long pressure of the head producing traumatism.

Note.—Experience proves that when the occiput lies posteriorly, and rotation cannot be effected, and the accoucheur fails to deliver with the forceps, in some rare instances nature comes to the relief of the suffering woman at the eleventh hour, and the occiput rotates under the arch of pubis, and normal delivery is then accomplished.

This fact should be borne in mind by the practitioner, and he should delay until the last moment before proceeding to extremities.

SOCIETY PROCEEDINGS.

MASSACHUSETTS GYNÆCOLOGICAL CLUB.

DISCUSSION OF DR. LOUGEE'S ARTICLE. (See this journal, page 127, March, 1889.)

There was general agreement among the members present, as to the efficacy of curetting, but not as to the necessity and advisability of the caustic applications.

Dr. Bennett questioned the safety of dilating, curetting, etc., in the office, and others thought it wiser to do it at the patient's home, or in a hospital that she might remain in bed for a time afterward.

Dr. Boothby believed the curetting, if thoroughly done, to be sufficient in most cases, without repeated caustic applications, which Dr. Lougee believed to be essential to complete and sure cure of granular endometritis. Dr. Boothby recited a case in which curetting had given temporary relief to metrorrhagia from supposed granular inflammation; but after this had been repeated four or five times it was thought that indications existed of disease beyond the endometrium, and laparotomy discovered disease of the fallopian tubes and a small ovarian or par-ovarian cyst. These were removed, and the result was improvement for some time, but later examination had shown enlargement of the uterus probably from adenoid or possibly sarcomatous growth, and he felt that vaginal hysterectomy should have been made. This case was to show that even radical treatment of the endome-

tritis is not a sure cure in all cases, as other conditions hidden behind this might exist, or the inflammatory process might extend to the tubes and ovaries, in spite of this treatment.

Dr. Lougee believed that in this case, if, after the first curetting, the local application of iodized phenol had been followed up for two or three months, it might have been curative.

The methods and means of dilating the cervical canal were discussed briefly, rapid dilatation by divulsors being generally preferred.

Dr. Whitmarsh observed that the gynæcologists whom he had seen operate in New York generally depended upon the cessation of hemorrhage and inability to find loose débris with swabs of absorbent cotton, as proof of the thoroughness of the curetting.

Dr. Phillips thought the results reported by Dr. Lougee should lead us to question, at least if not to put to the test, whether his practice of repeated applications after curetting would not accomplish more than the operation alone.

AMERICAN INSTITUTE OF HOMŒOPATHY.

The Bureau of Gynæcology will devote the coming session to the consideration of

"DISEASES OF THE FEMALE BLADDER AND URETHRA."

The Chairman's address in general session will consist of a synopsis of the bureau report, with thoughts and comments upon the general subject.

The following programme will be presented, viz :

"Urethritis—Acute and Chronic," by M. T. Runnels, M.D., of Kansas City. Discussion of same to be opened by S. P. Hodges, M.D., of Chicago.

"Acute Cystitis—Ætiology, Diagnosis, and Treatment," by J. C. Wood, M.D., of Ann Arbor. Discussion of same to be opened by O. S. Runnels, M.D., of Indianapolis.

"Chronic Cystitis," by J. W. Streeter, M.D., of Chicago. Discussion of same to be opened by Phil. Porter, M.D., of Cincinnati.

"Some Anomalous Affections of the Urinary Organs in Women," by R. Ludlam, M.D., of Chicago. Discussion of same to be opened by T. G. Comstock, M.D., of St. Louis.

A general invitation is extended to all members of the Institute to present any valuable experience or observations bearing upon these or kindred subjects during the general discussion following the above report.

L. A. PHILLIPS, M.D.
Secretary.

ALBERT CLAYPOOL, M.D.
Chairman.

THE TRIP TO MINNETONKA.—There are few sections of our country that afford more real interest to the traveler, than that traversed by the Chicago, Minneapolis, and St. Paul line of the Chicago and Northwestern Railway, and there are no lines that afford more genuine comfort than this. Leaving Chicago the line passes northwesterly through northern Illinois and southern Wisconsin, passing Janesville, Madison, Baraboo, Devil's Lake, Elroy, Eau Claire and numerous other points of interest. The first part of the journey is through a region that has become famous for its agricultural, stock, and dairy products, affording a most interesting epitome of the progress, wealth, and power of the people of this section. Later the lake regions of western Wisconsin are traversed. The four beautiful lakes at Madison, picturesque Devil's Lake, and the rugged and in many cases sublime scenery of the Wisconsin and Baraboo rivers are passed, affording infinite variety and never-failing attractiveness of scenery. As to equipment, it is perhaps enough to say that no pains have been spared to make it a strictly first-class line. Its complement of dining-cars and day-coaches is of the most superior quality and workmanship—ministering to the artistic taste as well as to the comfort and luxury of passengers. Fast vestibuled trains are run through between Chicago, St. Paul, and Minneapolis by this line, connecting in union depots at both points with trains for the short ride to Lake Minnetonka.

TRANSLATIONS FROM FOREIGN JOURNALS.

The Editor is assisted in this department by Dr. S. Lillenthal, San Francisco; Dr. H. H. Crippen, San Diego; Drs. Pick and Pritchard, Boston.

—**VENTROFIXATION OF THE UTERUS.**—*Société de Chirurgie*, séances 16, 23 and 30 Janvier, 1889. Terrier thinks he was the first who performed that operation in France. His first operation happened through a diagnostic error. A young woman suffered from severe pain on one side of her abdomen, where a painful tumor at the side of the uterus existed, and retroversion. Considering it a salpingitis, laparotomy was performed. Considerable retroversion, and on the lateral side of the uterus the ovary was found in the plica Douglasii. Terrier fixed the anterior surface of the uterus to the anterior abdominal surface, and put the ovary in its proper place. A rapid cure followed. At the end of the year the sutures were still firm, and there was only little sen-

sitiveness of the uterus. The second patient suffered since 1885 of severe pains, in consequence of retroversion and hypertrophy of the uterus. Last October laparotomy was performed, and the uterus found bent deeply backward in the pelvis. After some difficulty it was raised, the degenerated tubes and ovaries removed, and the uterus fixed to the anterior abdominal walls with four catgut sutures. The third case was a similar one, and both women are doing well. Routier reports another successful case.

Desprès asks whether the bladder was not compressed in consequence of the operation, and remarks that in deviation the uterus only becomes painful when it has passed through inflammatory changes. Simple retroversion does not need ventrofixation. Where the deviation becomes painful, which usually happens about the time of menstruation, rest is the best remedy. In simple retroflexion pessaries are injurious, and the perineal girdle suffices.

Lucas Championnière advises the fixation of the uterus as high up as possible, and the bladder is never disturbed.

Polaillon made several successful operations, but uses silk or silver thread, as catgut becomes absorbed and the uterus then deviates again.

Terrier reports another new case, where he operated on account of prolapsus which could not be brought into position. After laparotomy he found adhesions of the intestines with the fundus uteri, and a fluctuating tumor connected with the left side of the uterus. Anteriorly the uterus adhered to the bladder. Loosening the adhesions, the tumor was extirpated and the fundus fixed to the anterior abdominal wall. A perfect success.

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—AN ECHINOCOCCUS PREVENTS LABOR.—Dr. Dieckman (B. K. W.) relates: A 4-para passed nicely through her first labor, but during the second and third labors the babes could only be extracted after great exertion by version, on account of a tumor at the external genitalia. Dieckman found at the exterior vaginal wall a tumor of the size of a child's head, tense, elastic, with a broad base, similar to a large cyst; the os uteri fully dilated, but the

head could not pass the tumor. An incision into the tumor brought on a discharge of a thick fluid, containing more or less bladders of different size, which the microscope demonstrated as echinococci. Half an hour afterward a lively boy made his appearance.

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—CONTRA-INDICATION TO ANTIPYRIN DURING MENSTRUATION.—Huchard reports that he witnessed several cases where, after taking one gramme of antipyrin, the menstruation suddenly ceased and symptoms of intoxication (severe chill, cyanosis of the face and extremities, and repeated fainting spells) were observed. It ought never be given during the first days of menstruation.—*Revue Gen. de Ther.*

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—Among the reports of the strange tissues found in dermoid cysts, the *Recueil d'Optalmologie* gives that of Dr. Bangarnstern, in which it is stated that a dermoid cyst of the ovary which he removed contained the rudimentary formations of the organs of vision. With regard to the origin of dermoid cysts, this discovery is hardly in accord with J. Bland Sutton's ideas. We think this question as to origin can not be definitely settled yet, as none of the theories upon the subject of dermoid cysts of the ovary correspond in all points with pathological facts. "Included foetation" hardly accounts for the supernumerary teeth, which are sometimes found to the extent of one hundred. Parthenogenesis, or the production of successive individuals from a single ovum without renewal of fecundation, is of course absurd. However, Dr. Poupinal presents us with some new ideas on the subject, in which he shows that every gradation can be traced between the common multilocular cyst and the dermoid cyst. The former is lined with the mucous membrane, which may bear every pattern of mucous gland. The latter is lined with skin, which may bear all kinds of epidermic appendages. Mixed cysts are invested with a partially mucous, partially epidermic lining. Dermoid cysts are claimed, then, to be a transition from the common form of cyst. Besides this, Mr. Sutton, the well-known English pathologist, claims that not only do the transitional stages exist between cysts

with mucous lining and cysts with a lining of epidermis, but that he has found transitional stages between the pathological cyst with mucous lining and the Graafian follicle. These assertions, however, have not been verified by others, and besides this, the presence of rudiments of the organ of vision, which can not be considered an *epidermal appendage*, leads us to believe there is yet room for investigation as to the origin of dermoid cysts of the ovary.

* * *

—ELECTROLYSIS IN INTERSTITIAL UTERINE FIBROMA.—(*L'Art Médical*, Jan. 1889.)—Dr. Delétang has operated since 1884 in about a hundred cases of interstitial fibroma, considering fibrocystic tumors and fibroma with pedicles not amenable to electrolysis. Immediate effects of intra-uterine electrolysis consist (1) in contraction *en masse* of the uterus and of the tumors from the beginning of treatment, but this contraction is not constant; (2) congestion of all the organs taken in by the circuit, nearly constant, lasting ordinarily several hours, accompanied by colic; (3) sometimes rapid disappearance of a pre-existing hemorrhage.

Its consecutive effects are: (1) hemorrhages; after a transitory increase, disappear; (2) the pains and the functional ailments improve. These phenomena are hardly in proportion to the volume of the tumor, as they stand more in relation to the inflammatory zone which surrounds these productions; (3) finally the mass diminishes; but we must distinguish two stages: (a) the peripheric inflammatory zone is absorbed; the fibroma, more disengaged, appears smaller and harder, but its retraction is only an apparent one. To this absorption we must attribute the segmentation of the great masses and the mobilization of the adherent fibroma so often observed. About this time the morbid symptoms disappear as the general health improves. The momentary aggravation of all the symptoms at the beginning of treatment arises from the congestion of the inflammatory zone. (6) Finally the fibroma itself retracts, but this is not constant, for the electric current has far more influence on the metritis or its symptoms than on the fibroma itself. Notwithstanding the persistence of the tumor, now hard and easily borne, the women consider themselves cured, for they are now free from all their former com-

plaints. Sometimes an atresia of the cervical canal remains which yields easily to dilatation. The operation is performed with currents of moderate intensity, generally 100 milliamperes, in severe cases somewhat stronger; five minutes suffices each time, and the operation ought to be repeated every five or six days. Under the second conditions intra-uterine electrolysis is without danger, though it takes a little more time than Apostoli allows, who is in the habit of urging stronger currents.

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ON THE RELATIONS OF PUERPERAL MENTAL ALIENATION AND PUERPERAL INFECTION.—DR. T. Y. HANSEN in *Allg. Med. Cent. Zeit.* 20, 1889.—Puerperal mental alienation is an effect of puerperal infection. In all puerperæ with symptoms of mental disease, symptoms of infection could be shown, and the form of this mental disease, acute hallucinatory dementia, hints to a toxic or infectious origin. Puerperæ infection, like any other acute infectious disease, may produce in predisposed persons hallucinatory dementia. In most cases it sets in at the acme of the infectious malady, more rarely during incubation or after the febrile stage. Often the somatic morbid symptoms are more pronounced, and the mental disturbance is then taken as a febrile delirium, but there is no difference whatever between such a febrile delirium and the psychosis from infection; *the action of a poison on the brain is always the cause of these symptoms.* Where the mental disturbance sets in before symptoms of infection are present, most probably the case will be a severe one. The cases mentioned as delirium acutum are only the most severe form of delirium per infectionem. In most cases there is only a hallucinatory dementia, and only in rare cases stupidity is observed. Among forty-nine cases where the mental disturbance set in during the first weeks of the puerperium, somatic symptoms of puerperal infection would be demonstrated in forty-two cases. In forty the mental disturbance began or ran its course as acute hallucinatory dementia; in two cases were short attacks of mania, which might be considered as deliria. The other seven cases showed the same mental disturbance. In two cases eclampsia and albuminuria preceded the attack; after cessation of

the sopor, hallucinatory obtuseness remained with anguish and agitation. An epileptic puerpera often had had hallucinations after confinement; another one suffered from melancholia during her pregnancy, had eclamptic fits during labor, and suffered from mental alienation afterwards (long-continued albuminuria). Another one died on the third day with delirium acutum. She was tuberculous, and probably there was septicæmia. In two cases, where no infection could be shown, the mental alienation also differed from psychosis by infection. One had a regular mania, the other a melancholia without hallucinations.

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—After a most thorough and complete test, hydronaphthol has been accepted as a superior antiseptic—more so than mer. cor., iodoform, eucalyptus, or carbolic acid.

Creolin, another favorite antiseptic employed by the Germans on account of its supposed harmless nature, has proven quite the contrary, as in several instances it has produced severe poisoning effects.

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—PILOCARPINE IN PUERPERAL ECLAMPSIA.—Dr. M. Fourrier was called at midnight, on Nov. 24, to a woman in labor who had been seized with convulsions. He found her suffering from eclamptic attacks. She was twenty-one years of age, primipara, and at term. Health good while pregnant until a month before, when her legs had become swollen, and her mental faculties had become obscured. The pains began at 7 P.M. The *os uteri* was dilated $\frac{3}{4}$ of inch, and head presented with the occiput to the right and behind. He at once bled the patient, but consciousness did not return. She had a third attack at 1:30, and he administered chloroform. Effected delivery at 5 A.M. with the forceps. Half an hour after the removal of the placenta the attacks recommenced, and he again bled the patient. Later on in the morning the attacks set in once more, and did not subside under chloroform. At 2 P.M. her condition was critical, she was cyanosed and pulseless, the extremities were cold, and death appeared to be imminent. He then injected subcutaneously two centigrammes ($\frac{1}{4}$ grain) of nitrate of pilocarpin. The effect was

magical. Ten minutes after the injection an abundant diaphoresis set in, lasting for over half an hour. The pulse became perceptible, and no further attack occurred. A second injection was given in the evening. Her urine was then still highly laden with albumen. On the following day two more injections were made, and in the evening the patient recovered consciousness, then progressed as favorably as could be wished. A month later the albumen had altogether disappeared from the urine, and recovery was complete.

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—A MONSTROSITY.—By DR. MARTIN COHN, of Hamburg. Translated by Albert Pick and F. Pritchard, Boston, Mass. (*Central-Blatt für Gynäkol.*, No. 8, 1889.)—On the 5th of August, 1888, I was called to assist at the labor of Mrs. A. She, a *primipara*, gave birth, unassisted, to a mature child, which, immediately after birth, cried quite vigorously and moved its limbs quite actively. The mother was strong and said that she has always been well. In the fourth month of her pregnancy she had severe abdominal pains, which disappeared later on. Monstrosities have never appeared in the families of either parent.

This monstrosity consisted of an eventration of a large portion of the abdominal organs. These lay upon the skin of the abdomen, the genitals, and the thighs, forming a large tumor. The largest part was formed by the greater curvature of the stomach, which was of a bright rose-color, the vessels being greatly injected. The duodenum and small intestines had become strongly adherent, and colored a dirty greenish yellow. Distinct peristaltic movements were to be seen, and on the child crying loudly still greater portions of the intestines were pressed out, and often the spleen and bladder appeared at the corners of the tumor.

The child lived twenty-eight hours, taking repeatedly during this time nourishment, diluted milk, and discharged meconium several times. Gradually the respiration became weaker, and the projecting, bare parts became darker.

The post-mortem examination nine hours after death revealed the following condition: Length 45 cm., cranium well formed, plentiful growth of hair, its greatest circumference 32 cm., fon-

tanelles $2\frac{1}{4} \times 4$; the spinal column, completely normal as well as the formation of the thorax and extremities.

On the abdomen was the above-mentioned tumor, consisting of the stomach and intestines. The stomach of the corpse was strongly meteoric and of a dark brownish-red color. The greater curvature was 12 cm. long, the blood-vessels strongly injected. The convolution of the adherent small intestine-coils had a hard leathery feel; the intestines were strongly meteoric, partly darkly bluish red and partly of a dirty gray color. If one lifted up the entire mass then one was able to see that the entire skin of the abdomen as far as a slit in the umbilical region, between two and three centimeters long, was entirely intact. The distance of the slit from the symphysis pubis was about four centimeters. On the left side of the slit the umbilical cord was attached. Hence the eventration was bordered by a relatively very small opening which showed itself to be identical with the point of exit of the umbilical cord.

Upon opening the abdominal cavity one could see that the liver occupied the space of both hypochondria, it lying like a half-moon up against the entire diaphragm.

Kidneys normal, supra-renal capsules very large and sanguineous. The intestines lying within the abdominal cavity strongly contracted and pale-gray; the large intestine filled with greenish masses.

The walls of the small intestine were enormously hypertrophied, so that the lumen would scarcely allow the passage of a catheter. They contained a large amount of a greenish-yellow contents.

The mesentery was infiltrated by a jelly-like substance.

The heart and lungs were normal.

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— FACIAL PARALYSIS OF THE NEW-BORN.—By STEPHAN.—Translated by Albert Pick and F. Pritchard, Boston, Mass. *Journal des Sages Femmes*, II., 1889.—There are in the new-born at least three different forms of peripheral facial paralysis:

1. Paralysis caused by the application of forceps.
2. Paralysis caused by a slow labor, a defective formation of the pelvis, or by an intra-pelvic tumor.

3. Paralyzes which are generally accompanied by a diminution of hearing, which are purely congenital.

While the first two varieties have a very good prognosis, as regards a complete cure, the third is incurable and persists the entire lifetime. The accompanying functional difficulties are not great, as the subject accustoms himself to the condition, not having ever heard normally on the paralyzed side. If the accoucheur has made a diagnosis in the new-born child of peripheral facial paralysis not caused by the application of forceps, he will do well in general to delay his prognosis, for if the affection be the result of pressure, generally it will disappear, but if it be on the contrary purely congenital, it will remain throughout the whole lifetime.

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—TRANSMISSION OF PNEUMONIA AND PNEUMONIC INFECTION FROM THE MOTHER TO THE FÆTUS.—(*Bulletin Méd.* 21, 1889.)—The studies of Professors Straus and Chamberland have demonstrated the possibility of the passage of the bacteria of anthrax (charbon) from the mother to the fœtus, and the same is possible with the microbes of many other diseases. The observations of Strachan and Morehand report three mothers suffering from pneumonia, and who gave birth to children during the eighth or ninth month of their pregnancy, and the infants died from the second to the fourth day from lobar pneumonia, and in the case of Thorner the pneumonic lung was full of microbes similar to those of pneumonia. Netter saw a woman who was in her sixth pregnancy enter the hospital suffering from a fresh pneumonia of the right superior lobe, and a week afterwards the disease had nearly run its course. On the ninth day she passed through an easy confinement and gave birth to a living, well-formed child, which died after five days. The autopsy shows a pneumonia of the right upper lobe, a double fibrinous pleurisy, a pseudo-membranous-pericarditis, a suppurating cerebro-spinal meningitis. The right heart contained a fibrinous clot, formed during agony, just as we find it in the pneumonia of adults. Microscopic examination revealed lancolated pneumococci in the diverse exudations and in the blood of the left heart. The infection must nec-

essarily have taken place through the placenta. We know that in the pneumonic the blood carries the pneumococci. Twice we witnessed it in the blood of uterine blood-vessels after abortion, and the transmission of pneumonic infection is now an established fact in man and animals. But we must also look to cases where the babe shows a pneumonic infection without determination to the lung. Toa and Affredozi report cases of two fœtuses expelled at four and at six months from pneumonic mothers. Though not showing pneumonia, the liver, spleen, and their blood were full of pneumococci. What is true of pneumonia holds also good with other local inflammations, which might be caused by the pneumococcus, though no pneumonia is seen. When the mother suffers from such an infectious disease, it may produce pneumonia in the fœtus. Hecker speaks of a mother succumbing to suppurating meningitis, whose babe died from lobar pneumonia with pleurisy and pericarditis.

* * *

—GENESIS OF PUERPERAL ECLAMPSIA.—(*Bulletin Méd.* 26, 1889.)—Bar observed a case of eclampsia where the patient during the days preceding the attacks showed none of the habitual symptoms of albuminuria gravidarum. She died next day, and at the autopsy the kidneys were only slightly affected, while the liver showed small hematomata, softening and friability of the hepatic tissues. Tarnier led our attention to the fact that during pregnancy fatty degeneration of the liver may take place, and we then find very little premonitory œdema, and the urine may hardly show any albumen before the attack sets in. Premonitory symptoms are a more or less severe pain in the hepatic region and the symptoms of a commencing intoxication; headache, epigastric pain, etc., and often puerperal mania. This eclampsia may remain benign, but when severe, it is mostly fatal; the women die in coma with high temperature. There may be also cases of eclampsia in the course of acute atrophy of the liver beginning with a chill, followed by fever with or without jaundice; in all such cases death is the rule.

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ON PEPTONURIA DURING PREGNANCY.—By A. KÖTTWITZ.
Translated for the "JOURNAL OF OBSTETRICS," by F. Pritchard

and Albert Pick, Boston. (*Deutsche Med. Wochenschrift*, xxx. 1888.)—Köttwitz is of the opinion that, peptonuria during pregnancy is a sure criterion of the death of the foetus, taking as a basis the numerous urine analyses which he made in three cases observed by him. In these three peptones made their appearance in the urine, which later on was followed by casting off of the dead ovum.

It is known that peptonuria makes its appearance in those affections in which albuminoids, leucocytes, disintegrate and are absorbed. The conditions necessary for these processes are present in the uterus after the death of the foetus. Already the liquor amnii contains albuminoids; the foetus may be regarded as a compact albuminous mass which becomes decomposed and macerated by the alkaline liquor amnii. The placenta is also affected by this process; degeneration—and resorption—processes take place.

In the three above-mentioned cases, Köttwitz was able to prove peptonuria, one of which was of especial interest, as the woman while parturient was attacked by trismus and tetanus, and died post-partum. He also gives a complete history of the case, with addition of a case of trismus and tetanus following abortion. He was never able to prove the presence of peptonuria in normal pregnancies, neither in a pregnant woman suffering from chronic nephritis. Also not in a nonipara who, while six months pregnant, suffered from repeated hemorrhages and finally was delivered of living twins; even after repeated and frequent urine analyses no peptones were to be found.

Although the number of observations which Köttwitz has made is but small, yet one can not deny that the conclusions which he has drawn from these contain very much which is probable. It is therefore desirable that his investigations be continued by others on a wider basis. If Köttwitz's investigations be confirmed, then we have in peptonuria a sure criterion of the death of the foetus even in the earlier months, which has been previous to this entirely wanting.

(Dr. Posner in a recent article on the subject of "Detection of Albumen and Peptones in Urine," in the *Arch. für Anat. and*

*Physiol.**). 1881, describes a very delicate test by which peptonuria may be detected.—Remark by the translators.)

EDITOR'S TABLE.

—Anthropometry, according to one of our foreign exchanges, is acquiring new significance. Its meaning is being extended from "measurement of the dimensions of the different parts of the human body," to include an application to human beings, mentally, morally, and physically, of the measuring rod, the balance and the chronometer, as rigid as their use in chemistry and physics. Certain experiments in these directions concerning heredity are interesting; thus, it has been ascertained that any peculiarity in the father appears in the son, reduced, on the average, to just one-third of its amount.

A deviation from the normal in one man appears reduced, on the average, two-thirds in a brother born later. This average reduction of personal deviations in one's relatives is called "*regression*." Thus the regression from father to son would be said to be from one to one-third, from the known brother to the unknown brother two-thirds. Calculations of regression from uncle to nephew to be two-ninths have also been made. It is doubtful if anthropometry can ever become a science; doubtful if it ever can furnish us that means of *prevision* which shall be its test. For instance, taken in the direction of the heredity of disease, will it be possible to formulate a law of "*regression*" from which can be exactly calculated the proportion of a disease that will be transmitted through each factor of a generation? Could such a power of prevision be ours, what a wonderful advantage would be in our hands! Knowing the proportion of disease or of deviation from a normal standard that a child inherited, precautions could be taken in the way of hygienic measures to prevent the development of that disease. Besides this, if we could establish a law of average reduction, a law of the average amount of "*regression*," in the inheritance of diathesis, it might remove some of the

*Translated in the *N. Y. Med. Times*, Sept. 1888."

difficulties in the way of tracing the shading-off of inherited syphilis, of scrofulosis, of climate and of food influences into that series of pathological states, at one extremity of which we place defaults of physical development and at the other hysterias and allied neuroses, and even that vague neuropathic diathesis which displays itself in its modifying effect by instituting a lessened resistance of the sympathetic ganglia.

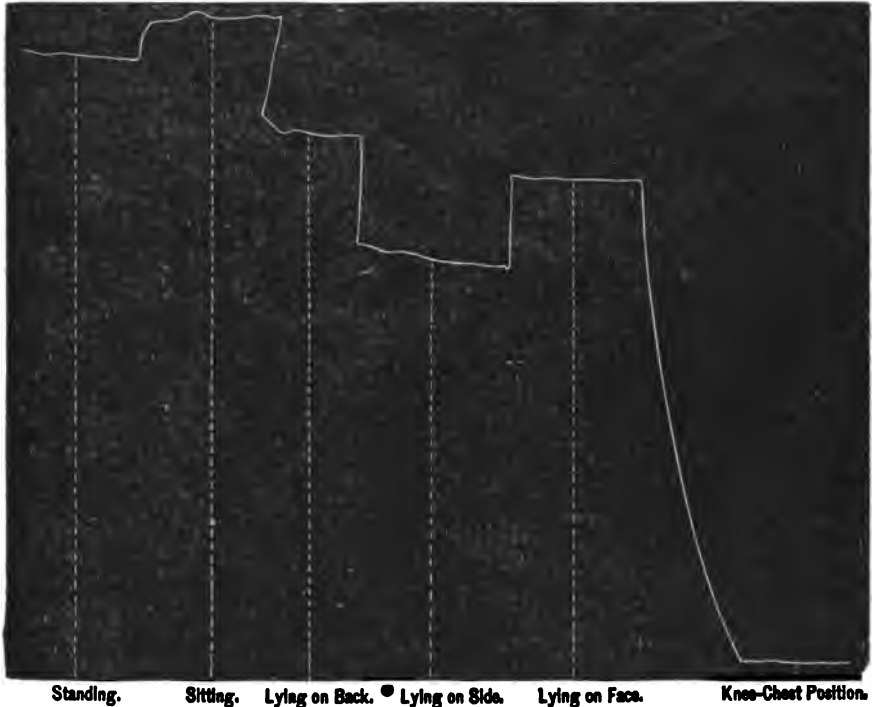
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Another, and perhaps more practical view of anthropometry, if we may be permitted the use of the word in the more extended sense of general measurements as above, has been taken by Dr. J. H. Kellogg, of Battle Creek, Mich. ; as we learn from some "Experimental Researches respecting the Relation of Dress to Pelvic Disease in Women." The measurements given by Dr. Kellogg relate to the differences in abdominal and costal breathing with and without the corset. From the facts of measurements of both of these types of respiration, undertaken among the Chinese women, who wear no corset and only loose clothes, and among the Indian women, who wear practically no clothes at all, it is concluded that "the so-called female or costal type of respiration, which prevails among civilized women, is the result of their restricting and unphysiological mode of dress, and is not due to the influence of gestation." This conclusion is the same as that arrived at by Dr. Mays of Philadelphia, and the author only disagrees with him in his belief that this costal breathing is a provision against pulmonary consumption.

With regard to this deduction of Dr. Kellogg, that the costal type of respiration is due to woman's mode of dress, it has an important bearing on the development of various forms of pelvic disease. Thus a mode of dress which interferes with abdominal breathing produces partial immobility of the uterus, and by interrupting the rhythmical movements of the diaphragm inhibits the influence of this muscle over the portal circulation and the venous system of the pelvis. To argue with dear inconsistent womankind on the folly of such dress is futile except in rare cases, but we may hope that a steady drip of words of advice may wear away even the stony heart of Fashion.

Among the cuts in Dr. Kellogg's work is one that interests even more than comparative measurements of costal and of abdominal breathing, and we produce it here to speak of certain important points connected with it.

The tracing in this figure was obtained by means of an air pes-



sary in the vagina, the movements caused by intra-pelvic pressure being recorded upon a revolving cylinder.

Starting with a pressure at zero in the knee-chest position, the influence of position on the intra-pelvic pressure is traced in the various attitudes of the woman's body. From this we may learn that what we have held before as careful facts agree in the main with scientific representation.

The difference between the height of the curve when sitting and that when standing demonstrates the necessity of exercise

for women, and the deleterious influence of a constant sitting posture in predisposing to pelvic congestion. Finally, the much lower curve of intra-pelvic pressure in Sims's position compared with that when lying on the back is also of importance as impressing that advantage which we have so often urged as belonging to this position in gynæcological work ; that is to say, the advantage of having the pelvic organs placed for manipulation under a much lower intra-pelvic pressure than in the dorsal position.

GYNECOSMOS.

—The Empress of Austria has appointed a lady doctor among her suite.

—The latest invention to lighten woman's work is a cradle which rocks by clock-work mechanism, and at the same time plays baby tunes.

—For once a woman's tongue has failed her. "Are you ill?" asked a physician. "Let me see your tongue, please." "It's no use, doctor; no tongue can tell how ill I feel."

—The Marchioness of Lansdowne has also joined in this work, and the fund for providing female medical aid to Hindoo women is now so firmly established that an annual income of 30,000 rupees is assured from the permanent investments which have been already made.

—Woman's medical education is receiving a remarkable impetus within the past year ; for, besides the fund for female medical aid to India, we learn that the Empress of Japan has established a college for women, which will include a medical department. Two American ladies are appointed on the board of trustees of the college.

—According to Chinese history, the small feet among the females of that people originated several centuries back, when a large body of women arose against the government and attempted to overthrow it. To prevent a recurrence of such an event, the use of wooden shoes was enforced on all female infants, so small as to disable them, without great pain, from making use of their feet.

THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

A. L. CHATTERTON, EDITOR AND PUBLISHER.

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VOL. XI.

URETHRITIS.*

BY MOSES T. RUNNELS, M.D., KANSAS CITY, MO.

GENERAL REMARKS.—Gonorrhœa in the female is not so typical and pronounced as in the male. In the latter the catarrhal processes are originated as a rule by gonorrhœa. When we discover an epididymitis, or acute prostatitis, or a purulent secretion from the urethra, we justifiably infer a gonorrhœal origin. In the female we cannot proceed with as much certainty. Irregularities in the physiological functions of menstruation and pregnancy and general diseases may cause catarrhal affections of the genital organs, which in turn occasion not infrequently disease of the uro-poetic system. The uterus and appendages may be affected by some of these conditions. The uro-genital tract is therefore not affected by gonorrhœa to such an extent in the female as in the male. We cannot in the female depend altogether upon the microscope to assist us in deciding whether the disease is dependent upon a gonorrhœa. The gonococci are plentiful in the acute stage of gonorrhœa, but in the chronic form they are difficult to find. The acute stage is short, and the chronic stage is usually what the physician is called

*Read before the American Institute of Homœopathy at Lake Minnetonka, June 28 1889.

upon to treat. The modesty of women, even of the lower grades, and the fact that the gonorrhœal disease in the female is in its acute stage very mild, are probably the chief reasons that medical men are not called upon to treat this disease in its inception. This accounts for the want of careful study by medical men of this disease in the female. The primary gonorrhœal diseases in the female are urethritis and vaginitis. These are followed immediately by other conditions which are very disastrous.

We may find the causes of urethritis either in the person affected, or they come from without. The urethral mucous membrane may be affected by hyperæmia, acute or chronic catarrh, ulceration, or hypertrophy, when the urine contains for any length of time (1) a superabundance of salts; (2) ammonia; (3) fungi; (4) membranous threads from diphtheritis of the bladder; (5) blood clots.

A direct lesion of the mucous membrane is sometimes caused by passing a catheter, bougie, or sound, or by the extrusion of calculi. Diseases of bladder and kidneys are predisposing causes of urethritis. Streubel has found urethritis as a complication of the scrofulous diathesis and with impetiginous skin eruptions. In scarlet fever and measles I have seen a specific urethritis set up. In two instances Scanzoni states that he had seen variolous pustules in the urethra in smallpox, and he found more than twenty follicular ulcers in the urethra of a girl nineteen years old who died of measles. Frequently in typhus, dysentery, and puerperal septicæmia the urethra becomes greatly disturbed in its nutrition. Ulcerations of carcinoma, lupus, syphilis, diphtheria, elephantiasis, or tuberculosis may invade the urethra from the labia minora and the introitus. The active and passive hyperæmia and mechanical displacement sometimes caused by pregnancy also affect the urethra. It may suffer a rupture or laceration in delivery, either with or without instruments. The peri-urethral plexus and the blood supply of the other pelvic organs are so closely related that

displacements of the uterus, tumors of the pelvic organs, or inflammations of the same, are great sources of irritation to the urethra. Diseases of the rectum, in one form or another, cause inflammations of the urethra of a serious character. A pre-existing urethral inflammation may often be aggravated by menstruation. I have witnessed some very distressing inflammations of the urethra in young women after marriage, which were probably brought on by cohabitation.

The introduction of foreign bodies (masturbation), unclean specula, careless use of the finger, tents for dilatation of the canal, or wounds from falls or blows, occasion inflammations of the urethra. Taking cold is a prolific cause of urethritis.

There seems to be one opinion among recent specialists as to the frequency of blennorrhagic urethritis. They generally agree that it is never absent in cases of recent infection. Among the older writers we find that Swediaur never observed a case of urethritis in the female; that Zeissl holds that there are only five cases of urethral blennorrhœa among 100 cases of blennorrhagic vaginitis; that Ricord believes that in contagious blennorrhœa of the female the urethra is often affected alone; that Cheron states that in the female there is one acute urethritis to five chronic urethritides; that Suchanek found, in 166 cases, the vagina and urethra both affected in 122, urethral gonorrhœa alone being present only in three cases; and that Winckel says that most frequently these affections occur conjointly with maladies of the vagina, and especially together with virulent vaginal catarrh. It is generally agreed that the virulent urethritis feminæ is usually secondary, and it is communicated from the mucous membrane of the introitus, or the vagina.

Dr. Wm. H. Baker, of Boston, says that probably the great majority of cases of urethritis are of specific origin and secondary to gonorrhœal infection of the vagina.

Sigmund examined 763 cases of gonorrhœa in the female. In this number there were 476 of vaginitis and urethritis

together; 282 of vaginitis alone, and five of uncomplicated urethritis. Lewin found only eight cases of urethritis in 242 blennorrhagic women, and in 612 pseudo-syphilitic women eleven had urethral sores. Among prostitutes we find blennorrhagic diseases common—at least two-thirds of the total number of infected cases can be classed as gonorrhœa. In 425 blennorrhagic women Hourmann found but one case of urethritis.

SYMPTOMATOLOGY.—Both the specific and the non-specific, the acute and the chronic, forms of urethritis feminæ have so many varying degrees that the diagnosis is not always easy to make. The acute specific form gives the diagnostician the least trouble. In health the mucous membrane at the orifice of the external urethra is pale-red in color. This color is changed to a rosy cherry, or brownish-red, in hyperæmic conditions; the mucosa becomes œdematous, and the vagina is narrowed and warmer by thickening and inflammation. In the beginning no increase of secretion is apparent, but later a light mucous or mucopurulent fluid comes from the meatus, which can be considerably increased for an instant by pressure from behind and forward on the urethra, which is felt as a firm cord and is very tender. No discharge of this nature can be expressed from a healthy female urethra. The discharge shows, on microscopical examination, gonococci in the pus cells, the same as in man.

In virulent urethral gonorrhœa, after an incubation of two to five days the woman first notices an itching in the urethra, soon to be followed by a prickling sensation, with frequent micturition attended with great pain and a sensation of heat. In three or four days a serous, glutinous secretion is found coming from the urethra, which is changed to a purulent and greenish discharge a week later. In about three weeks this discharge begins to abate, and by the end of six weeks may wholly disappear. The inflammation may be so active as to cause a discharge of blood

and a vesical catarrh. However, the short and straight course of the female urethra and the absence of large glands render it less liable to severe urethritis than in the male. The urethra in man is divided into two parts, but this is not so in woman. According to Finger, of Vienna, we find in the female bladder a true sphincter, consisting of smooth and striped muscular fibres, and constituting "a sharp boundary between the urethra and bladder." In man there is a neck of the bladder which at times belongs to the urethra and at times to the bladder. In woman the urethra is on an average about $1\frac{1}{2}$ inches in length, and about $\frac{1}{4}$ inch in diameter. It is open anteriorly and closed towards the bladder, so that regurgitation of urine or any of the secretions from the urethra into the bladder cannot easily occur. We know that the capacity of the female bladder is greater than in the male, but even when distended it holds all the urine perfectly.

When urethritis becomes chronic the discharge from the urethra gradually diminishes, the inflammation subsides, and the mucous membrane takes on a livid blue color. The urethra may be felt as a hard and infiltrated canal, not painful, and on pressure from behind forwards a milky muco-pus may be seen at the orificium externum urethræ. In order to form a correct diagnosis of hyperæmia and catarrhal, or virulent, urethritis the mucosa of the vulva and surrounding parts are to be subjected to thorough examination by feeling and seeing. The thickness, hardness, and sensibility of the urethra should be determined by touch. The presence or absence of gonococci in the secretion from the urethra must be decided by the microscope. The existence of elastic fibers in the secretion will be proof that urethral chancre is present. If the inguinal glands become involved and a bubo appears, we shall be further aided in our diagnosis. Should "clap shreds" and cloudiness be found in the urine passed after thorough cleansing of the vulva, we may expect to find a chronic urethritis.

The follicles located around the female urethra may be involved in any blennorrhagic process of the canal and become swollen, sensitive, and noduled. This condition may subside without further trouble, or may run a very tedious course. Pus is often secreted, and suppuration follows, or the pus may find an outlet into the urethra through small canals, one or more. The follicles at the orifice may undergo acute inflammation, which may relapse and become chronic. This process is liable to result in suppuration in the follicle affected. Other follicles around the urethra participate in the gonorrhœal inflammation, and so it may be protracted. Skene's glands may be affected by chronic inflammatory conditions of the vulva and urethra. Great tenderness will be found at the urethral orifice, and when pressure is made against the anterior vaginal wall just behind the meatus, a drop of pus from their mouths will escape when the glands have taken on catarrhal inflammation. An irritable bladder may be a prominent symptom, but this is also frequent in case of urethral caruncle. So long as these glands remain in a catarrhal condition, the patient will have exacerbations of urethritis.

Acute urethritis may sometimes be mistaken for cystitis. In the latter the vesical tenesmus and the constitutional effects are more pronounced, and the escape of pus can only be noticed at micturition, while in urethritis it escapes in the intervals. It is well for the specialist to remember that in diagnosing gonorrhœa in the female he should see with his nose and fingers, as well as with his eyes.

The prognosis of urethritis in the female is usually more favorable than in the male. The chronic form is usually more easily treated, and the chances for recovery are, on account of the anatomy of the parts, considerably greater.

TREATMENT.—In acute urethritis accompanying vaginal gonorrhœa, or exposure to cold, or traumatism, a palliative treatment should be adopted.

Hot vulvar and vaginal douches, with warm sitz-baths,

should constitute the local treatment at the outset. We have learned more of the nature, course, and pathology of gonorrhœa in the female than we knew a few years ago. We can make better diagnoses, and our remedies are not so numerous or confusive. If the gonorrhœal disease in the female is recognized in its inception and properly treated, it is soon over. Hot vaginal irrigations increase reintegration, and a mild antiseptic in the water—as boracic acid, sulphite of soda, or sulpho-carbolate of soda—does much toward retarding the multiplication of gonococci. It is necessary that the parts should be kept cleansed. No injections of the urethra are allowable until the inflammation of the urethra becomes sub-acute. It takes usually a week or ten days for this to occur. Injections of the urethra are at no time so useful as in the male, because the female urethra is short and will not retain fluid so well. When the acute stage has somewhat subsided, there is no doubt but that the injection of hot water—as hot as the patient can bear—several times daily, by the use of Skene's reflex catheter, does a great deal toward effecting a speedy cure. The old-school treatment, by the use of injections of hypermanganate of potash, sulphate of zinc, alum, tannin, etc., and the local application of tincture of iodine, or a solution of nitrate of silver, or carbolic acid, or fine point of a Paquelin cautery, are expedients which no homœopathic physician should ever resort to. When the cause of the inflammation is known we may begin treatment by removing it, if possible. Rest, abstinence from intercourse, cool mucilaginous drinks, and soft foods, with no stimulants, tea, or coffee, should be ordered. Much depends upon keeping the diet healthful and restricted, and the mind free from excitement. The hygienic treatment with rest in recumbent posture will surely cure many cases of specific urethritis feminæ. Two to four vaginal injections of hot water should be taken in the recumbent posture each day. No internal remedy is so generally indicated in the begin-

ning as aconite in the lower attenuations. It does very much toward relieving the irritation, pain, and burning, and is useful until these symptoms have somewhat subsided.

The symptoms I have found to call for aconite most are as follows: Nervous excitability; acute inflammation of the urethra; vagina hot and sensitive; urine scanty, red, and burning; painful, anxious urging to urinate; great burning distress in the urethra when urinating.

Cannabis sativa has not served me so well as aconite in the acute and specific forms of urethritis. It is indicated when the discharge becomes purulent and yellow, with burning and smarting while urinating. In doses of five to ten drops of the tincture this remedy has done most service for me. I have used it in all attenuations, and have come to the conclusion that the remedy is prescribed too frequently and very often empirically. *Cantharis*, which is so frequently indicated in cystitis, is also a valuable remedy in urethritis when symptoms of the kidneys and bladder appear as follows:

Gonorrhœal discharge of mucus and purulent matter from the urethra; desire to pass urine almost constantly; burning and scalding pains in the urethra; intolerable tenesmus; dull, aching pains in the regions of the kidneys; burning and cutting pains from the kidneys down either ureter to the bladder. These symptoms may be accompanied by hæmaturia.

I get the best results from *cantharis* in attenuations above the third decimal dilution.

Mercurius solubilis and *corrosivus* are very reliable remedies when the discharge becomes green and purulent, and is worse at night. Extreme cases of violent tenesmus, burning and swelling of the urethra, require *mercurius corrosivus*. The allopathic physicians are using this drug as a specific for gonorrhœa. Great burning between micturition is an indication for *mercurius solubilis*.

In old and oft-repeated cases of gonorrhœal urethritis I have found thuja of great value when symptoms as follows occur:

Sycotic excrescences, or whitish ulcers, on the labia, which are swollen; urethral discharge thin and green; mucous leucorrhœa; desire to urinate almost constantly; can pass but a few drops of bloody urine at a time, with a great deal of smarting and itching; walking produces stinging, itching, and smarting pain, with contractive and pressing pain in the genitals.

Septia is another remedy of great value in chronic urethritis, especially of a specific origin. The micturition is more frequent at night, and is attended by burning pains; vulva and vagina are both painful to touch and dry; milky or yellow leucorrhœa with considerable itching of the genital organs; bloody discharges from the urethra when walking; no discharge from the urethra except at night, when a few drops appear, staining the linen yellowish.

There are special indications for other remedies in urethritis too numerous to mention here. Some of the most prominent of these are equisetum, hyemale, petro-selinum, clematis erecta, conium, capsicum, copaiva, cubeba, argentum nitricum, pulsatilla, belladonna, nux vomica, and berberis vulgaris.

If Skene's glands become diseased by the gonorrhœal process, they should be "slit up along their urethral aspect by means of a pair of fine-pointed scissors."

Subacute catarrh is usually due to irritation or impeded circulation, and disappears as soon as the cause is removed, but a urethritis dependent upon gonorrhœal infection may sometimes linger for months, and be complicated with cystitis. In chronic cases of urethritis, where the walls of the urethra are very much thickened and the canal narrowed, dilatation with steel sounds is recommended. The sound is not to be introduced oftener than once or twice per week. The metallic sounds should be used whenever a stricture of

the urethra is found. Sometimes the urethra is so contracted and surrounded by cicatricial tissue, forming bands, that it is much distorted and very tender. The smallest sounds may be admitted with difficulty.

The specialist needs to be on the lookout for vesico-urethral fissure in all protracted and very obstinate cases of urethritis and cystitis. An examination of the urine will be sufficient to decide whether the latter is present, and the endoscope will enable the diagnostician to exclude urethritis and detect vesico-urethral fissure. This fissure or ulcer is usually developed from urethritis.

Dilatation of the urethra by means of steel sounds is the remedy for this very aggravating trouble. If dilatation fails to cure the vesico-urethral fissure, then Emmett's button-hole operation should be made to establish a vesico-vaginal fistula. Skene says: "The fistula may be allowed to close of its own accord, as it usually will do. By the time the fistula closes the fissure will have healed." In acute or chronic urethritis it is very important that the portal circulation should be kept in a normal condition, by securing a healthy action of the liver and bowels. If a good general circulation can be maintained the local affection will not be so severe. I have found mineral waters (notably the Waukesha, Wisconsin, the Saratoga, and the Excelsior, Clay County, Missouri) of great value in the treatment of urethritis and cystitis. By the use of one of these waters the action of the kidneys is increased, and the urine is rendered less acid and irritating. The bowels are more easily moved each day, and the homœopathic remedies are more effective.

BIMANUAL EXAMINATION OF THE FEMALE PELVIC ORGANS AND POSTURAL TREATMENT OF DISPLACEMENTS.

BY C. G. HIGBEE, M.D., TACOMA, WASH.

Physicians who practice gynæcology for many years may become very expert in diagnosing diseases or displacements of the female pelvic organs by bimanual examination. It does not require great skill or experience to enable the examiner to determine the exact form and density of the uterus, or to trace the ovaries and their ligaments, when the case is a favorable one. However, beginners need not be at all discouraged if they are unable to verify their diagnosis by this method. There are many cases where it is difficult to feel the ovaries. It is only in those patients that have become emaciated, or whose abdominal muscles are relaxed, and that are free from adipose, that we can determine the condition of the ligaments and fallopian tubes when they are in their normal place and condition. There are cases where examination proves very unsatisfactory in one position, where by placing them in another we are enabled to complete our diagnosis or treatment.

In sensitive, nervous patients, the contact of the physician's hand on the abdomen will cause a contraction of the muscles, so that the whole anterior of the pelvic organs will be beyond the reach of the hand or fingers. In such cases a change from the dorsal to the knee-elbow position will very much aid us. We can profitably bring electricity to our assistance in these cases, either to relax the contracted muscles or to cause contraction of the uterus, so as to bring it and its attachments more nearly within our reach. We can pass one pole of the battery with our fingers into the vagina and use the other over the abdomen.

If we find that a patient is in the habit of lying exclusively upon the back or either side, and feels more pain or

discomfort when changing from this position, we may be quite sure that the organs are abnormally crowded to that side, and perhaps adhesions are also complicating the case.

In such cases the best results from our examinations will be gained by placing the patient on the opposite side from the one she habitually lies upon. If the usual position is upon the back, place her in the knee-elbow position in making your bi-manual explorations. At times it is necessary to use some instrument in the uterus or rectum, or both, at the same time we use each hand. No doubt every physician has at times wished he had *three* hands to use as one. As we are not endowed with that number, we must supplement those we have with instruments.

Not alone in making a diagnosis is the bi-manual method practically useful. By placing the patient in the knee-elbow position, and using two fingers in the vagina to hold the os-uteri back as far as possible, and with the other hand to massage the abdomen, and, if necessary, to push the uterus from side to side, the most persistent cases of retroversion can be restored to a normal position. Even in cases where it is supposed adhesions have taken place, they may be broken up, and the uterus replaced in a normal position. We apprehend that those cases where adhesions have actually taken place are not the most troublesome to the patient, unless the organ lies very low. If the inflammation subsides, and the adhesions are formed, they may act as a support to the uterus and sustain it in the abnormal position until the patient becomes accustomed to it, the tenderness subsides, and there is not as much suffering as there was previous to the formation of the adhesions. For this reason, among others, we would deprecate the use of much force in trying to break up such adhesions.

When the patient's abdomen is nearly free from adipose deposit, and not otherwise, can we seize the uterus with both hands over the abdomen, with an assistant to raise and press back on the uterus. Fortunately this is not necessary,

for by using the method as above indicated the uterus can be raised to the full length of the vagina. After replacing the uterus, we can best retain it until the ligaments contract and are strengthened, in either prolapsus or retroversion, by placing the patient on her side, and giving strict injunctions not to turn on the back. When turning from side to side, have them do so by the face for obvious reasons. By persisting in this course, and supporting the uterus with a vaginal tampon whenever the patient is obliged to use unusual exertion, we can cure any case of uterine displacement when there is no laceration of the cervix or perineum.

All our efforts should be directed to relieve the pelvic organs from abnormal weight and pressure and consequent hyperemia, following this by rational methods of exercise, posture, and manipulation, until the nerves and muscles regain vitality and strength, avoiding as much as possible mechanical support.

In directing treatment in any case, we must bear in mind the action of the lungs and diaphragm in elevating the abdominal and pelvic organs, and also the force of gravitation upon the parts.

ACUTE CYSTITIS.*

ITS PATHOLOGY, ETIOLOGY, SYMPTOMS, DIAGNOSIS, AND TREATMENT.

BY JAMES C. WOOD, M.D., ANN ARBOR.

Any lesion giving rise to the symptoms and sequelæ present in acute cystitis as manifested in women, demands, and has received by numerous writers, most careful consideration. Indeed the ground has been so thoroughly traversed that there is little opportunity for an essayist to suggest innovations, or to relate experiences that are not already trite. There is, therefore, little encouragement to

*Read before the Am. Institute of Homœopathy.

work the literature for data. The acute stage of cystitis is of short duration, and terminates either in resolution, or merges into the sub-acute or the chronic forms, in which the pathological changes are much more decided and the range of treatment much less restricted.

Acute cystitis in women is a disease probably more frequent than the student is led to infer from the teachings of many of our more prominent gynæcological authorities. While it is a lesion not confined to women, yet the anatomical peculiarities of the female bladder make it an organ easily invaded either through the urethra or through the walls from above. The uterus and adnexa posteriorly and superiorly frequently implicate it in a reflex way or by direct transmission, while the vagina is lined with a mucous membrane often the seat of specific or non-specific inflammation, which is readily conveyed through the urethra to the bladder. Again, the numerous injuries following in the train of parturition are still other reasons why the organ is so often the seat of inflammation.

In its pathology there is nothing peculiar or remarkable. The changes will vary somewhat, according to the severity and violence of the attack, yet they are not unlike those found in inflammation of any mucous membrane.

At the outset the existing hyperæmia gives the membrane a bright-red appearance, which soon becomes swollen and relaxed. At certain points the epithelium will be destroyed, particularly at the summit of the rugæ, between the folds of which and in the sulci pus is usually found. These, in brief, are the ordinary changes incident to the disease. Occasionally the destructive process is much more decided, especially in certain cases following prolonged distension. The whole mucous and sub-mucous tissue may become involved, the entire lining membrane of the bladder being shed or cast off *en masse*. Usually this accident is post-puerperal, at which time the general congestion and succulency of all the pelvic organs would favor it. During con-

finement pressure upon the neck of the bladder or upon the urethra causes tumefaction of the parts and consequent obstruction. As a result the urine is retained for an indefinite length of time, the dribbling from the over-distended organ deceiving both nurse and physician, until the excessive intravesical pressure cuts off the capillary circulation from the mucous membrane, causing in due time its partial or complete death, after which it is exfoliated and cast off. This at least is the explanation given by Liston, and it seems a very probable one. Skene suggests that where the distension has been sufficiently great to cause separation, the death of tissue may be due to excessive congestion following sudden emptying of the organ. The succeeding changes are those of chronic cystitis, with which this paper is not to deal.

The etiological factors of acute cystitis are both numerous and varied, some having already been suggested. There is by no means a consensus of opinion as to whether or not it ever occurs as an idiopathic affection. While not as profoundly impressed by the causes giving rise to general pelvic congestion as are the uterus and the ovaries, yet the blood-supply of all of the pelvic viscera is derived from the same general source, and it therefore requires no great stretch of the imagination to believe that cold or undue exposure may excite cystitis. However, in the vast majority of instances the trouble can be traced to unmistakable exciting causes, and it is reasonable to believe that women with scrofulous tendencies of other mucous membranes are more liable to have catarrh of the bladder when exciting causes exist than are those free from constitutional bias. At any rate the slightest irritation or exposure will, in some women, cause irritation, or actual inflammation, of the bladder.

Of the various exciting causes none is more important than parturition, to the improper conduct of which many a mother owes her invalid life. Cystitis is here produced either by the undue and prolonged pressure of the foetal

head, by retention of urine, or by septic invasion, all preventable causes in most instances. Of those originating from within the body, abnormalities of the urine are to be noted, yet in a bladder perfectly healthy it is difficult to comprehend any unnatural condition of the urine sufficiently marked to excite an inflammation. Unfortunately many bladders are not perfectly healthy, being at all times more or less congested and irritable—a condition that may be fanned into true inflammation by urine loaded with lithates or with pus. Abnormal urine is, however, oftener the result than the cause of cystitis. Of those originating from without the body, we may enumerate traumatism, the introduction of foreign bodies by masturbators, uncleanly and unskillful catheterization, and unnatural or violent coitus.

The bladder, like all other organs of the body, is predisposed to inflammation by any condition causing a chronic congestion. Disorders of the heart, liver, and kidneys act in this way. Again, in acute exanthematous diseases the vesical mucous membrane may sympathize with the tegumentary tissues, and even become seriously involved. The well-known action of certain drugs upon the urinary tract we, as homœopaths, are perfectly familiar with, and will recognize their disturbing influence in looking for etiological factors. As has been intimated under the head of pathology, diseases of contiguous organs may implicate the bladder. Whether or not the inflammation produced by gonorrhœal infection differs from non-specific inflammation is at the present time *sub-judice*, and it would be an intrusion upon your time to discuss the question here.

Acute cystitis, while often giving rise to symptoms most decided and pronounced, does not affect the organism as does the chronic form. In the simpler types of catarrh the symptoms appear suddenly, there being a sensation of distress and weight back of the pubes, with increased frequency of micturition, which is more or less painful. The degree of tenesmus varies according to the extent to which the

vesical neck is implicated. The urine is but little changed, is slightly acid or neutral in reaction, and may be clouded. The specific gravity remains unchanged, and if there is a sediment it will contain an increased quantity of leucocytes, with or without phosphatic crystals.

Even when acute cystitis is purulent from the outset the general disturbance may not be very great, except, as Richardson observes, in those attacks due to bacterial invasion following labor. In these cases the outset is announced by a severe rigor, followed by a temperature curve ranging from normal in the morning to 103° or 104° F. in the evening. The hypogastrium may become very tender and the dysuria and tenesmus unendurable. In the purulent form the changes in the urine are more decided, it being ammoniacal, invariably alkaline, and containing pus and blood in varying proportions. The sediment contains, besides the blood and pus corpuscles, triple phosphate crystals, bladder epithelium, and bacteria.

It is not within the province of this paper to discuss those forms of acute cystitis which occur as a local expression of severe constitutional diseases, as diphtheria, erysipelas and croup. They are always of serious import, and demand of the attendant prompt and vigilant treatment.

There may be some difficulty in differentiating acute cystitis from acute urethritis, especially if the subjective symptoms alone are relied upon. Severe pain in the latter trouble occurs only during, and lasts but a short time after, micturition. It is also said that there is an oozing of pus more or less continuously from the urethra in urethritis, whereas in cystitis pus escapes only during micturition, and the urine which escapes last is more cloudy than that first discharged. The uncertainty of this test is, to my mind at least, very great.

When the pus comes from the kidneys there will be more albumen than can be accounted for by the total quantity of pus and blood present in the urine. Again, in

renal diseases, the tube casts, and the absence of the pain during micturition and in the region of the bladder, ought to direct attention to the kidney.

In prolapsus uteri there may be frequent urination, not unlike that produced by cystitis, but the normal condition of the urine and the aggravation arising from standing or walking will at least suggest the cause of the trouble.

The dysuria arising from vesical neuroses is characterized by its sudden appearance. If there is any change in the character of the urine it is of a purely temporary character. In adhesions of the bladder the desire to empty the organ is only urgent when it becomes partially distended. The urine would also remain unchanged. Fissure of the bladder can be positively determined only by the use of the endoscope.

In the treatment of cystitis, prophylaxis is of the first importance, and the various causes enumerated should be carefully avoided or removed. Unclean catheters should be banished from the lying-in and the operating ward. Any form of hard instrument, with the possible exception of the glass tube suggested and used by Küstner, should be discarded because of the difficulty in keeping it perfectly aseptic. I much prefer the velvet-eyed soft rubber instrument, because, if perfectly clean, it is non-irritating, and its inexpensiveness enables each patient to have an instrument of her own. Where repeated catheterization is necessary, a new one should be substituted every two or three days. After use it should be carefully washed and cleansed by forcing a stream of water through it, and then immersed in a 10 per cent. carbolyzed solution until again required. The vestibulum should always be carefully washed before introduction. Unless absolutely necessary catheterization after operations should not be resorted to. Even after abdominal section the patient is usually able to urinate with much less distress than the introduction of the instrument causes, and experience has fully demonstrated the harmlessness of per-

mitting healthy urine to come in contact with plastic operations. With the possible exception of vesical fistula I no longer draw the urine, unless in those cases where swelling and tumifaction have temporarily occluded the urethra, or when, owing to some peculiarity of the patient, she cannot urinate while in the recumbent posture.

On the other hand, the operation is frequently called for in post-puerperal conditions, and the importance and necessity of examining the bladder carefully during the first few days of the puerperium cannot be too indelibly impressed upon the mind of the student. A very large proportion of the cases of cystitis date back to childbirth, and in no instance should the statement of either nurse or patient be relied upon as regards the passage of urine, especially if there be dribbling. In consultation with Dr. J. W. Wheelock, of Bancroft, Mich., I once saw a parturient woman moribund, with symptoms of septicæmia and uræmia, where the bladder reached the umbilicus, giving to the abdomen the appearance of tympanitic enlargement, so great was the distension. Catheterization rewarded us with two large-sized *pots de chambre* full of urine which two distinguished men of the *regular* school had permitted to accumulate. The obloquy is thus permitted to fall upon that school because Skene in his latest work, and in almost the same language, charges the same negligence "to a member of the so-called *new* school."

Abnormalities of the urine when they exist should be corrected, and hemorrhoids, fissures, or any disease of neighboring organs should be removed. *Necessitas tollendæ causæ* is quite as evident in the treatment of cystitis as in the treatment of any other inflammation.

In the management of an acute cystitis, rest more or less absolute should be insisted upon. The recumbent posture should be maintained, and if the vesical pain and tenesmus are very great, much relief will be afforded by the hot sitz-bath or vaginal douche. If the urethra is also implicated, a

stream of warm water falling upon the external meatus for ten or fifteen minutes three or four times per day will often relieve suffering to a marked degree. Concentrated and irritating urine can be diluted by permitting the patient to drink freely of either water, milk, or some mucilaginous fluid. The diet should be unstimulating and bland, milk being the best of all articles. These precautions, in conjunction with the homœopathic remedy, will, in probably the larger proportion of cases of acute aseptic cystitis, accomplish a cure. Aconite, belladonna, cantharides, cannabis sativa, chimaphilla, mercurius cor., and arsenicum comprise a list of remedies frequently useful. After a duration of a week or longer without manifest improvement, the disease will have assumed a sub-acute or chronic character, and will often demand local treatment before a cure is completed.

UNCERTAINTIES OF THE SIGNS OF PREGNANCY.*

BY LAMSON ALLEN, M.D., SOUTHBRIDGE, MASS.

Occasionally the diagnosis of pregnancy can be easily and accurately made, because the signs thereof, both subjective and objective, are definite and visible. But more often, when the patient, herself in doubt, applies to the physician for a diagnosis, it is very difficult and perhaps impossible.

It seems to have been the lot of the writer to meet with some of the latter cases. I do not mean that it is necessary for diagnosis that we have all the signs of pregnancy present in any one case in order that we may determine it with surety. There may be a number or only a very few of them and still the facts in the case be reasonably rare.

Perhaps we can best introduce the subject by citing a case. A lady, accompanied by her husband, presented herself with the following history and symptoms :

* Read before the Wor. Co. Hom. Med. Soc., May 8.

She has been married fifteen years. Has two children, both living, aged thirteen and ten years respectively. No miscarriages. When her first child was born she was very sick for over two days. There was no rupture of the perineum, but there was one of the cervix uteri. When the child was six days old, her husband was taken down with violent delirium from typhoid fever. As only his wife could quiet him, she arose from her bed and nursed him. From that day she has never been a well woman. At the birth of her second child, now ten years of age, she remained in bed for fifteen or sixteen days. Up to the time when she presented herself, she has been steadily but slowly declining. As the years passed on there was a gradual increase in three prominent symptoms, named in the order of their access and growth, viz: leucorrhœa with dragging distress in the pelvic and abdominal regions; severe sick headaches; and diphtheretic sore throats. The latter were becoming exceedingly frequent, and each seemed to be as bad as or a little worse than the preceding. I had attended this patient for the first time two months previous to her coming to my office for one of these sore throats. At that time there was diphtheritic exudation, fetid breath, and extreme prostration. I have often asked myself in connection with these cases, whether there is any pathological connection between these two affections, occurring as they often do in the same patient. Is the diphtheretic sore throat a sequela of endometritis with ulcerative cervicitis?

It was in August, 1888, that this patient first applied for treatment. Besides the above history was the following: She has not menstruated since June, now two months previous. But that was not strange, since she had been very irregular for nearly a year, during which time she would skip two or three months at a time. During the last year her health had rapidly declined so that she is now hardly able to do the light work of her house. She has profuse leucorrhœa all of the time, a distressing dragging ache in the

pelvic and abdominal regions, at times a peculiar faintness in the scrobiculus cordis, and the headache. There was no morning sickness, neither was there any change in the areola of the nipples.

Specular examination revealed the following: The vagina was congested and hot; the inferior portion of the bladder was prolapsed. The cervix was lacerated bilaterally half-way to the internal os, was greatly œdematous and severely ulcerated. There was metritis of the cervix, the walls of which were œdematous and flabby. The uterus was in size large enough to fill the whole pelvic cavity. The husband and wife being anxious to know whether or not there was pregnancy present, I told them that I did not think there was, but that it was next to impossible to give a definite answer when there was so much disease in the parts. At any rate there was grave necessity for treatment for the metritis and the ulceration.

The case continued faithfully with the treatment. Not until the last of Dec., 1888, or the first of Jan., 1889 (being sixth and seventh months respectively), was there anything like movement felt, and that only very indistinctly, nor was the growth of the uterus, prior to the above dates, anything commensurate with the age of the foetus. During all this time, nothing definite could be obtained by ballottement, for there was no bag of waters present, as we find at delivery.

Efforts were made repeatedly up to January, 1889, to discover foetal heart-beat and uterine souffle; but they were unsuccessful.

At some time near the first of September, there was a slight bloody discharge per vaginam. At that time it was supposed to be an effort on nature's part at menstruation. But in the light of past events it was probably an abrasion of some part of the severely ulcerated surfaces of the cervix from some unknown cause.

During her other two pregnancies she had more or less

of morning sickness. At this time, and in fact during the whole time of this gestation, there was no sickness whatever.

Treatment, which was continued during the whole of the pregnancy, was successful, and on March 29, 1889, she was delivered of a healthy child. Up to the present date, she is doing finely and feeling better than since her first confinement.

A review of this case will show that there was not, up to the last of the sixth month of pregnancy, a single definite symptom of the fact thereof. To be sure, menstruation had ceased, and the os uteri was soft, but it was the softness of ulcerated and œdematous tissue. There was absence of all the common signs, viz: of morning sickness, ballottement, uterine souffle and foetal heart-sounds, the violet hue of the vagina, the discoloration of the areola of the nipples, softening of the vaginal cervix, and the usual changes in the growth of the uterus, and active foetal movements till late in pregnancy.

As regards ballottement we find in Lea Brothers' publication, "A System of Obstetrics by American Authors," p. 373, the following: "It is difficult—sometimes impossible—to elicit ballottement by the vaginal method, when the foetus is abnormally large or very small, in cases of excess and deficiency of the liquor amnii, in placenta prævia, in multiple pregnancy, and in pelvic and transverse presentations."

It is by our experience and sometimes by our mistakes that we learn what might take volumes to teach us. Not finding any of the signs of pregnancy, I stoutly maintained that it was not, and not until there was a slight semblance of motion at the close of the sixth month was my confidence in my own diagnosis shaken. The contour of the abdomen was a very inconstant factor in the case by reason of the appearance and disappearance of impacted flatus and what seemed to be peritoneal dropsy. But during the

first half of the seventh month the movements of the foetus and the growth of the uterus out of the pelvic cavity became definite and diagnostic.

In the light of such cases as all must meet more or less frequently, the subject becomes of exceeding interest and importance. There was one other means left to the diagnostician, viz: the use of the uterine sound. But under the circumstances its use would have been criminal, since in all probability abortion must have followed.

With such a case and under such difficulties, how can we give a definite and safe diagnosis during the early months of gestation? Supposing it was called for from some medico-legal aspect, what can be done? To use the sound would be unwarranted, and I can see no other way than to wait patiently for developments.

The sign of "softening and compressibility of the vaginal cervix" is fallible, as the following case will show. In November, 1886, a lady, thirty-nine years of age, presented herself, a stranger to me, for diagnosis of pregnancy. She was about 5 ft. 4 in. in height and about 175 lbs. weight. Menstruation had been irregular for several years. There had not been any show for nearly five months. She had two living children, ages twelve and eight years respectively. No miscarriages, and no morning sickness. There was a feeling of general malaise, but no definite symptoms pointing to any one organ that was diseased. There was no change in the breasts, neither was there the least semblance of motion. There was no pink or violet color of the vaginal mucous membrane. The vaginal portion of the cervix was as hard as a virgin's, and with undue confidence in the reliability of the last sign, I gave unhesitatingly a decided opinion that pregnancy was not present. Four months later she gave birth to a healthy child, and not until the beginning of the ninth month was this patient herself positive that she was enceinte. Ludlam says: "In doubtful cases, *time* will help you to differen-

tiate between a physiological suppression of the menses and one which is in every sense pathological. When complicated with retention, you may even have to wait until the fifth or sixth month before you can say with certainty whether the arrest of the menses was due to conception or to some accidental or morbid cause."

I would like an expression from the members of this society as to the approximate percentage of the cases examined, that will present the sign of "softening of the vaginal portion of the cervix." It has been my experience, that, where there is no metritis or ulcerated os, little more than one-half the cases present that sign. Frequently patients will come shortly after the time for the second menstrual epoch has passed, and want to know with certainty whether they are enceinte. They will present the following: Menstruation has twice failed to appear; there is no morning sickness. Vaginal examination reveals no change in the color of the mucous membrane, nor is there any softening or compressibility of the vaginal cervix. The breasts have not undergone any marked or definite change. How, I ask, can you say from such a case that there is surely either pregnancy or no pregnancy? I cannot. As a matter of experience it will be best to say that pregnancy is probably there, but the signs are not definite.

The Annual of the Universal Medical Sciences, Sajous, 1888, contains on p. 163, vol. iv., the following: "The peculiar color of the vagina as indicating pregnancy in its early weeks has been presented by Dr. Chadwick in a well-known contribution. More recently Dr. Farlow has made a study of 141 cases of pregnancy in regard to this diagnostic mark, and his results are as follows: it was characteristic in 70, suggestive in 35, and absent in 36. The author remarks that he also found in four cases the peculiar color: in one of the four it was quite characteristic, in the other only almost characteristic. Yet the women were *not* (italics mine) pregnant!"

Undue respect for the absence of some or all signs of pregnancy, as portrayed in works on the subject and in lectures to our students, will lead the inexperienced into errors which may be costly. It is well, therefore, to be very chary of committing one's-self absolutely in the matter, and in the case of the married, let the probabilities be on the side of conception, and, in the majority of cases, it will be the right side.

ELECTRICITY IN EXTRA-UTERINE PREGNANCY.

BY WM. H. KING, M.D., NEW YORK.

The use of electricity in extra-uterine pregnancy has become familiar to the majority of physicians. It, therefore, only requires a description of the method of administration. The method most generally adopted is to use the interrupted galvanic current; the negative pole, armed with a suitable electrode covered with sponge or chamois, should be introduced into the rectum or vagina (the one being selected that will bring the current in most direct contact with the foetal nest), and the other placed on the abdomen over the tumor. A current as strong as can possibly be borne, with frequent interruptions, should be passed for from five to ten minutes. All that is required is to cause the death of the foetus, and when this is accomplished treatment should be suspended. This may require but one treatment in some cases, while in others from five to ten will have to be given. They should be given daily, when possible; if this cannot be done, apply as often as the patient can bear it. The diagnosis of the death of the foetus requires great judgment, and, if no bad symptoms occur, the treatment had better be continued, so as to be on the safe side. There is one condition that I believe invariably follows the death of the foetus, and that is the

softening up of the mass. If the index finger can be run over the surface of the tumor while the foetus is alive, the mass will be found to be very hard and the surrounding envelopes will appear to be on the stretch from the internal pressure. But in about forty-eight hours after the death of the foetus this sack will become softened, as if some of the contents of the foetal sack had become absorbed. Some physicians prefer the faradic current to the galvanic, but it will require more treatments with the faradic, it is more uncertain in its action, and it possesses none of the catalytic action of the galvanic current, all of which are very important in this condition; and, on the other hand, it possesses no corresponding advantage. I, therefore, advise the use of the galvanic at all times. Just how the dead foetus is gotten rid of by nature is not known, but it is supposed that it is first changed to a liquid state and then disappears by absorption.

VISCUM ALBUM.

A CONTINUATION OF A SERIES OF STUDIES IN NEW REMEDIES IN GYNÆCOLOGY.

BY PHILIP PORTER, M.D., DETROIT, MICH.

SYNONYMS.—*Viscum Flavescens*, *Phoradendron Flavescens*. NATURAL ORDER.—*Loranthaceæ*. COMMON NAME.—Mistletoe, American mistletoe, white mistletoe. PREPARATIONS.—Tincture, from the fresh berries and leaves, fluid extract from the leaves.

During the early use of mistletoe in our practice we were very particular to procure the viscum album of the homœopathic pharmacopœia, that is, the preparation made from the European species, but in later years we have found that the American mistletoe acts equally well, and corresponds to the same indications as its foreign congener.

Indeed, since we have had the opportunity of comparing with the description of the *viscum album* of the southern and western countries of Europe a specimen of *viscum flavescens* sent us by Dr. H. H. Crippen,* we have no hesitation in declaring that there can be no more difference in the remedial action of these two varieties of mistletoe than there is between the action of *rhus tox.* and that of *rhus radicans*.

As to its history, mistletoe is accorded a place in antiquity as being prized by the ancient Gauls and Germans as a healing remedy. Even in the dark ages it was accorded by the priestesses, the female Druids, a close affinity with and influence upon the sexual organs. The antiquarian researches of Dr. Huber of Steger in upper Austria brought to notice this early use of mistletoe, with the result that he proved several dilutions on himself and others, men and women. Unfortunately Dr. Huber died, in the year 1858, before he could place before the public a collation of the symptoms experienced by his provers, and little is left to us of his knowledge save such as was given in conversation to a colleague, Dr. Von Gerstel of Regensburg.† From the latter we learn that according to Dr. Huber, "the symptoms of *viscum album* are similar to those of aconite, bryonia, pulsatilla, rhododendron, *rhus*, and spigelia, *i.e.*, are in accord with our foremost anti-arthritic and anti-rheumatic (?) remedies. *Viscum* has symptoms in common with each of these remedies, and is thus particularly useful in gouty and rheumatic complaints, in acute as well as in chronic cases, more particularly in those having tearing pains in no matter what part of the body. . . . As *causa excitans* of diseases amenable to it may be regarded high winds, *i.e.*, all gouty, rheumatic, or other ailments which, similarly to

* Collected in Texas, on the line of the Southern Pacific Railway, where it grows in large quantities.

† *Allgemeine Hom. Zeitung*.

thus and rhododendron, are aggravated by sharp northwest winds, such as we have in winter.

"The mistletoe, moreover, stands in a peculiarly close relation to the female sexual system [uterus], and especially to the climacteric period, when women cease to menstruate and chronic or periodical hemorrhages are often met with. Viscum also promotes labor-pains similarly to pulsatilla and secale, and is especially efficient in effecting the expulsion of the placenta, also in incarcerated placenta." Our friends of other schools of medicine have also collected some experience with mistletoe. Dr. Turnipseed of South Carolina, in the year 1851, called attention to the ecbohic action of a decoction of mistletoe. Little attention was paid to this until Dr. Long* also spoke highly of its oxytotic virtues, claiming it to be far superior to ergot: "1st. Because it acts with more certainty and promptness. 2d. That instead of producing a continuous or tonic contraction, as does ergot, it stimulates the uterus to contractions that are natural, with regular intervals of rest. Consequently, it can be used in any stage of labor, and in primiparæ when ergot is inadmissible." Dr. R. Lee Payne, Jr., led by the desire for a further physiological knowledge of the drug, has taken one step more in the right direction, and gives us as the result of experiments on cold and on warm-blooded animals the following general summary:

"Mistletoe is an irritant of the gastro-intestinal mucous membrane. We also conclude that it exerts, in cold-blooded animals, an action on the heart similar to digitalis, slowing its action by increasing the length of its diastole, at the same time increasing the length of its systole. In warm-blooded animals its action on the heart is more like that of belladonna, its force not only being increased, but its rate of impulse also, and—contradictory as it may seem—it must be that in frogs the heart is slowed by increase of its inhibiting con-

* *Louisville Medical News*, 1888.

trol and strengthened by stimulation of its vaso-motor ganglia, while in warm-blooded animals the increase in strength and rate of the pulse is due not only to stimulation of the vaso-motor cardiac ganglia, but also to a paralyzing action on the pneumogastric terminal filaments. It must also be noted that in too large doses, or if its action is too long continued, mistletoe, by over-stimulation of the cardiac motor ganglia, exhausts their irritability and paralysis results. The action of mistletoe on the pupil is also evidence of its stimulant action on the sympathetic nerves; and further, it is seen that in both cold and warm-blooded animals mistletoe exerts a paralyzing action upon the spinal cord and its nerves, both of sensation and motion, but the action upon the heart and pupil indicates a stimulant effect upon the ganglionic nerves. Whether this paralysis depends upon a specific action on the cord, or whether it be due to a diminished supply of blood, the result of the stimulation of the vaso-motor nerves, and consequent contraction of the arterioles, cannot well be determined, but the latter hypothesis I am inclined to adopt.

“ Mistletoe destroys the reflex functions of the spinal cord and lessens the electro-motor contractility of muscles.

“ As a result, then, of this determination of physiological action, and knowing that the uterus, like all unstriped muscles, is almost entirely controlled by the ganglionic nerves, it is easy to understand the alleged oxytocic virtues of mistletoe; and since the publication of my paper above referred to, a number of trustworthy observers have testified to me of its efficiency. Indeed, I am prepared to endorse not only all that Drs. Long, Todd, Lane, and others claim for it in this connection, but I would further add that in those cases of post-partum hemorrhage in which the loss of blood has been extreme, and the nervous shock so severe that we dare not give ergot lest paralysis of the heart result, mistletoe, from its stimulant action on the heart, may be

given with greater safety, and with even more confidence as to the relief of the flooding, than ergot.

"After an extended experience with mistletoe in cases of the retained placenta after abortion, I am fully persuaded that it will be found a most efficient remedy. Further, from its stimulation of the vaso-motor nerves and consequent contraction of the arterioles, mistletoe will be found to do good service in epistaxis, hæmoptysis, menorrhagia, metrorrhagia, and indeed all passive hemorrhages. That its action on the heart indicates its influence in all diseases of this organ characterized by weak action and low arterial tension, I have been able to demonstrate in practice, and in the *Practitioner* (November, 1881) will be found a note on viscum album by Dr. Roswell Park of Glasgow, who, referring to my paper, confirms my observations in this connection. Dr. Park states that, 'whatever the exact pathological condition might be, incompetency, and tumultuousness, and distressing cardiac action were the immediate symptoms calling for treatment in those that presented themselves.'"

Among others who have noted the action of viscum flaves-cens on the uterus are Dr. J. S. Todd, who says that mistletoe increases the natural rhythmical, intermittent pains or contractions of the uterus; Dr. Green of Atlanta, who uses it in tardy labor, and says it acts to increase only the length and tonicity of the pains, not notably affecting their frequency, and certainly followed by intervals of complete relaxation; and Dr. T. S. Henry, who classes mistletoe as narcotic, antispasmodic, and oxytotic, and calls particular attention to this last action, as more satisfactory than ergot in expelling polypi and small tumors from the uterus.

Among our homœopathic brethren who have noticed this remedy are Dr. E. M. Hale, who gives it place with other new drugs; Dr. D. B. Morrow, who in the *Medical Advance* indulges in a bit of attempted sarcasm on its use as a new remedy by saying that it has so great a reputa-

tion among Balize creoles for curing abdominal pains and cramps as to have earned the sobriquet of "God Almighty"; and Dr. Wm. Boericke of San Francisco, who gives a few indications for its use.

Among its symptoms we find: Pains, periodic, worse in bed, and from cold wind. Tearing, shooting pains from above downward in both thighs, with restlessness and prostration. In obstetric practice, weak pains, where it must be compared with actæ rac., caulophyl., puls., and secale cor., also in adherent placenta. In disease of the female sexual organs: hemorrhages accompanied by pain, blood partly red and partly in clots; hemorrhages with violent contractive, labor-like pains; hemorrhage continual, at one time in a stream, at another in clots of a blackish character. Pains, periodic, proceeding from the sacrum into the pelvis, worse in bed, accompanied with tearing, shooting pains from above downward, in both thighs as well as in the upper extremities, with sleeplessness and general prostration. Metrorrhagia at the climacteric. Areolar hyperplasia. Subinvolution.

Its action on the ovaries, especially the left, is to relieve dull, heavy, sagging pain. In one case of a young married lady, five months pregnant, who complained of a dull, heavy distress in her left ovarian region immediately after coition, mistletoe, five-drop doses, relieved in a short time. In one other clinical case of the same nature, pain in the ovarian region after coition, mistletoe cured in two weeks. Dr. H. H. Crippen of San Diego has also verified the symptom of pain in the left ovarian region during pregnancy, more particularly where there was pain as if the left ovarian region were pressed on by the enlarged uterus, with pains down the thighs and sharp, nipping pains in the vagina.

We believe, from the symptoms developed among our provers, that it has an affinity for erectile tissue. Unlike ergot, it does not depend upon the influence of gestation,

or upon the presence of a foreign substance within the uterine cavity, to develop its excitant action on the uterine muscular fibres.

DEAFNESS WITH MENSTRUAL PERIOD.—AND OTHER NOTES.

BY HENRY USSHER, M.D., WANDSWORTH, ENGLAND.

She hears better out-of-doors; her period has returned, but insufficiently; at first it was suppressed, and the girl was badly deaf. She has been twelve months under treatment. What could an allopath do with such a case?

The deafness, which was the latest addition to her distresses, was the first to yield. Her remedies were two; and I am impressed with the fact (perhaps wrongly) that many doses twice a day were requisite to meet this stubborn case. I think I got my clue in Allen's Repertory, kreasote, in the 2x, for the deafness. Improvement soon began, and the medicine was continued for some time, then puls. 6, which was suspended during the period. It is not a little curious that anomalies like these should attend menstruation, and they seem to be added to its irregularity; and while noting this case I may add that another patient years back had urticaria one-sided with her period, and she too was cured by kreasote 12. See Guernsey.

Lately I saw an uncommonly severe case of urticaria in a child some seven or eight years old. It came out immediately after the use of a particular beef essence, and at first sight seemed due to it. The child was covered with the eruption on arms and face, gasping for breath, rather livid, and to look at the child one would think she was dying. She had been taking for some days hepar 6x trit. in water for an abscess on the chin, and this I believe caused the attack. It was soon stopped by nit. 3x. I have heard some say that they never saw aggravations. Well, here is one,—and

I have seen the same *hepar 6x* produce most serious diarrhoea. There is a form of nausea that comes on from disuse of food in the sick; they either can not, or will not eat; here *kreasote* is efficient, say in the *3x*, for *2x* is unpleasantly strong to the smell; there is an unwholesome mucus to which the odor of the mouth bears testimony; the stomach belches imploringly. With women at climacteric there is a sensation of threatened paralysis, arm and leg, more commonly the former. *Nux 1* or *3x* is valuable, and if it fails *strych. phos. 1x*; these attacks excite alarm, but are amenable to steady use of remedies. In some parts of Kent where hops are largely dried, the air is impregnated with sulphur, a fearful illustration of too much of a good thing. The mother of the patient I now write of died from the weakness induced by it leading into dropsy, and the daughter showed excess of venosity to an exaggerated extent: her thighs were violet color; menstruation suspended; lung and heart all doing lazy work, and she looked the weakness she felt. Slow abdominal circulation, swelled feet, distended abdomen, repletion at small quantities of food at last suggested *lycopod.*, and I gave it *3x trit.*, with advantage. It has done much for a case of almost despair. *China, ars., puls.* were all helpful, and the period, though moderately painful, has been re-established.

Lately I had occasion to see a very rheumatic patient who was in deep grief and depressed by the death of a relative. She could hardly hobble from chair to chair; is over seventy years of age. *Ignatia* was given for the mental state, and it relieved the bodily pain and stiffness in a very marked way. In the unusual damp weather that we have experienced there has been much rheumatism with severe backache, and here *phytolacca* has been most useful; where the backache has not been so pronounced a feature, and damp has had full sway, *rh. tox. 12* has been my remedy. In prescribing this medicine I have noted that patients taking the *1x* or *2x* are more helped (some at least) when they

had the 12th. The question of dose is a subtle one, and not so plain as some make it. I have again observed that where I had given ignat. 3x and 12, the former to a girl with trismus, the latter to her mother, with vertical crushing headache, both were still more improved when they had ignatia; mother powder (φ cum sac. lac.) in small doses. As it is true in other things, "as is her mother so is her daughter," so has it happened with medicine again and again: the likeness of temperament is frequent. Some of us give ign. φ in 7-drop doses. Deliver me from their kindness, I fervently say; depression of spirits I once had from two drops ign. φ has left a memory that will not bear repetition. Could the doctor be occasionally persuaded to take a little of his own medicine he would gain a new experience.

People nowadays fumigate you with carbolic acid, and lather you with phenyl soap, in a very indifferent state of mind. I am not alone in thinking it harmful. Allen points out its action on left toe painful, and somewhere I read, but cannot put my finger on the place, that it produced an abscess under left toe. I thought I saw it in Allen's, but cannot recover the reference. Three times I used the phenyl soap, which is a fine cleanser,—twice on the back, and once on the scalp. I had no pressure on the toe, but an onychia and proud flesh came at the inner side of left toenail; this has lasted over three months. I thought to abort it, and sprinkled thereon in fine dust a small powder of plumbum nit., which pained me smartly, dried it up, and blackened it; and thinking I might get the whole thing out which troubled and lamed me, I applied Dredge's heal-all; valuable to an indolent sore. Blood came under the toe of the nail, and I found on pulling the growth that a fan-shaped process went under the middle of nail and showed plainly enough. Suffice it to say that in Hering's Domestic Physiology I got causticum suggested, and used it in the 6th for a lotion; the 12th smarted too much. For the

soreness at the nail side, I took arsenicum one dose, and silica for the state of the nail; the edge of the skin, hard as horn, I have removed twice. And some will say it was not the phenyl. Whoever is thus careless he is carbolically warned.

DIET AND MEDICINAL TREATMENT IN THE INSANITY OF PREGNANCY.

BY H. H. CRIPPEN, M.D., SAN DIEGO, CAL.

(Continued from page 265.)

DIET IN STATES OF MENTAL DEPRESSION.—There is no better meat than beef or chicken, and it is best that it be roasted or broiled, so that the inside be underdone and juicy. In some cases beef scraped or minced fine may be given raw, sandwiched between thin slices of bread, or dressed as a salad with tender portions of celery or lettuce, if it excites aversion in its crude state. Cooking serves to separate the fibers of meat, and otherwise prepares it for digestion, but the fact remains that it is more readily assimilated raw by some patients. The same thing may also be said of eggs, which in general are best soft boiled, poached on toast, beaten up with milk or in form of a custard. With many patients, however, it will be found that there is no form of albuminous material so immediately and easily assimilated as the whites of perfectly fresh eggs taken *au naturel*, with the addition only of a little salt.

Hypothetical objections may be made to the large amount of nitrogenous food here advised, but the views expressed are based on clinical experience. The imperfect oxidative changes, the dyspnoetic state of nervous centers, and the retarded metabolism of the whole organism in acute melancholia are well known. Now a largely nitrogenous diet hastens proteid metabolism, increases the number of red blood corpuscles, and augments oxidative activity in all

the tissues. In addition to other diet, relatively large quantities of milk (two quarts daily) will often serve to restore cutaneous functions—the skin becoming less dry and harsh, and to relieve constipation in a measure, especially if unskimmed milk is employed, or if one-eighth part cream is substituted. The physiological effect of the ingestion of large quantities of fluid in increasing blood pressure and restoring suppressed secretions is not without its application in these cases. It may be well to mention in this connection that a diet of equal parts of milk and cream carried to the full degree of tolerance in irritable and sleepless cases of melancholia will often, for a few days at a time, prove a most valuable sleep-producer and nervous sedative.

In some cases of mental depression the gastric juice, like the other secretions, is deficient, and the peptonic conversion in the digestion of milk does not take place, and in these instances resort must be had to peptonized milk, or its dry preparation, and for like reasons, if there is intolerance of fat, pancreatic emulsions may serve a useful purpose. As a kind of substitute for milk without casein, barley water with cream may merit some brief employment, as in the case of children.

As to the total daily quantity of fats and carbo-hydrates, it may be said that not less than 100 grammes of the former and from 300 to 400 grammes of the latter are to be used. The fat is already largely provided for in the above-mentioned allowance in the eggs and milk, but in addition from one to two ounces of but slightly salted butter, or its equivalent in cream, should be given in any manner most acceptable to the patient. Cod-liver oil is valuable, because it is a food rather than a simple medicament in these cases. The fat of cured ham, strange to say, is especially well borne in some instances, and the rule is to consult the idiosyncrasy of the patient, for it matters not in what form the fat be, if it is only assimilated, for all kinds of oleaginous matter are re-

formed before they are appropriated by the cells and stored up as human fat.

The important place the fats hold in the quantitative chemical analysis of the human nervous system accounts for their most useful dietetic rôle in melancholic cases. The more irritable, hypochondriacal, and hyperæsthetic the patient is, the greater is the benefit to be derived from a fatty diet. It is not to be forgotten, however, that proteid substances may furnish, through their carbon-holding portion, a certain amount of fat to the tissues, and that fat is always more readily accumulated upon a mixed diet.

Carbo-hydrates favor the accumulation of fat, and serve to supply heat and other kinds of force in the system, but if given in too large amounts, are apt to undergo undue fermentative changes, and to form gas and acids excessively in the gastro-intestinal canal. Their starchy portions are apt to be imperfectly digested in some cases of melancholia, for the following reasons: first, because the saliva in these cases is often only of the sympathetic variety, thick, viscid, and without the usual digestive action on starch; and, secondly, in that the pancreatic juice is usually deficient, and does not act its part in the conversion of starch into grape sugar. Long boiling of flour and other artificial aids may be applied with some advantage in these cases.

In the convalescent stages of melancholia it will be found, however, that the carbo-hydrates will be well borne, and they should then be given in large quantities, while the albuminous food is to be somewhat diminished. The gain of weight in this stage is astonishing, in some cases amounting to twenty per cent. in women and fifteen per cent. in men of the total bodily weight, and it is to be facilitated by such starchy and saccharine articles as may be most attractive to the taste. Indeed, the active sympathetic relation of the gustatory and digestive acts are never to be ignored in any stage of the disease, though vitiation or absence of appetite must not prevent sufficient alimentation. It would

be out of place here to describe the various methods of forced feeding so often absolutely necessary in insanity. Suffice it to say that one pound of the round of beef pounded to a pulp and passed through a fine sieve, and fed during the twenty-four hours with six fresh eggs and three quarts of milk warmed to 98° F. just at the time of feeding, with the addition of a little salt, is vastly superior to the meat extracts, beef tea, and various other things often employed. In addition to the nitrogenous, fatty, and hydrocarbonaceous foods, the acids and salts of fresh fruits and vegetables are essential to the proper nourishment of the patient. If fruits and vegetables, baked or stewed in the usual way, are not taken voluntarily, they should be made into a purée and administered mixed with milk.

The conclusion, as regards states of mental depression, then is, that the varied and full diet above recommended is essential, and that no part of it is to be dispensed with unless, from idiosyncrasy, it is found to disagree with the patient; that the total amounts of food named are best given in divided quantities every three or four hours during the waking hours of the patient, who is never to be aroused from sleep for purposes of feeding.

DIET IN STATES OF MENTAL EXALTATION.—“In asthenic mania fresh meats, eggs, milk, and fruits are to be given in somewhat larger amounts, but in the same relative proportions as in states of mental depression. In sthenic mania, with bounding pulse and pulsating carotids and signs of cerebral hyperæmia, the albuminoids should be decreased and fat and carbo-hydrates freely given. The latter are of high value in supplying the vast amount of energy which the patient instinctively expends. These muscular efforts are nature's way of diverting blood from an overcharged brain to the muscular tissues, and the constant movements serve as an outlet for the nervous force rapidly generated in cortical centers, and they should not be restrained by mechanical means, but the potential energy

which they demand should be supplied in the food as far as possible.

"The better maniacal patients are fed the less irritable and violent they become. Partial starvation has always been a part of the fate of lunatics, and the fact that the former ferocious types are seldom seen nowadays is due largely to the improved dietaries of hospitals for the insane. After the storm of acute mania is over there follows a stage of secondary exhaustion of mental and bodily forces, and it is at this time that stimulating nitrogenous food becomes again most useful, and should be given in as large quantities as can be assimilated."

DIET IN DEMENTIA.—In dementia, as the power of the cerebral cells degenerates, we find the functions of organic life becoming correspondingly strong. Digestion is performed with mechanical regularity and the patient grows fat.

Bodily waste and repair finally become equal, and the patient may maintain this equilibrium for years, the prospects of recovery decreasing with age.

"Now, if there ever be a time in the history of these cases for the practice of an economical diet, it is during this final stage. A minimum of proteid food, with a good share of the cheaper fats and carbo-hydrates, suffices to keep these demented creatures in comparative physical well-being. If absolutely the best thing is to be done for the patient, however, the diet must be constantly preserved at a generous standard, for so long as there is life there is hope of recovery, and the writer has seen recovery at the end of twenty years in these cases.

"Whenever the superior nervous centers suffer degradation from disease, it will be found that the tendency is to fatty degeneration of tissues, and if in these chronic cases of mental disease there should be any signs of return to reason proteid food should be given freely again to hasten nitrogenous metabolism, and the formation of the higher morphological tissues of muscles and nerves."

The moral treatment occupies a position of importance. False intellectual conceptions must be opposed, when occasion offers, by urging such arguments as would be accepted by a sound mind, until at last the patient comes to see the falsity of her reasoning or ideas. Cases may progress to a certain point and convalescence be arrested; such instances require change of scene, visits from friends, and above all sensible companionship. During the period of convalescence great harm may be done by association with gossiping, gabbling persons who are constantly reverting to the unsound state of the patient's mind.

The hygienic treatment includes, besides sanitary arrangements, occupation, both mental and physical. Endeavors to get the patient systematically employed are of value, and even in apathetic cases, where they may have to be looked after every few minutes, perseverance will be rewarded.

Hydrotherapy is of doubtful value. Hot baths have been very much in favor in French asylums, and some authorities in France claim very favorable results. The patient is kept in the bath from four to eight hours. The bath, when the patient is put in, is at a temperature of 100° F., and, being covered except a place for the patient's head, only loses about twenty degrees of heat, so that, when the patient is taken out, the bath thermometer stands at 80° F. In some asylums cool water is allowed to trickle upon the head while in the warm bath. In my experience the hot bath has not done as much as promised; the patient may be quiet in the bath, but on emerging returns to a violent state as in a case already given. If long continued hot baths are given large quantities of food are necessary, or the patient will collapse from the weakening effect.

The treatment by electricity deserves brief mention. Hammond recommends static electricity in the class of emotional insanities and in primary and secondary dementia. In Bethlehem there is little faith in its efficacy and its use

has been abandoned. On the contrary, Remak * states that he has seen good results from the use of the continuous current in morbid conditions of the brain accompanied by disordered mental functions. Benedict† is of the opinion that secondary mental disturbances are caused by an affection of the vaso-motor and may therefore be cured by galvanization of the sympathetic.

MEDICAL TREATMENT.—Our materia medica is rich in mental symptoms, and the future of homœopathy in the treatment of morbid psychological conditions is certainly promising. In giving indications for drugs clinical verifications will be largely depended upon and due credit given for practical analyses of symptoms.

Our chief remedies applying in this disorder, where the condition is characterized by mania, are belladonna, hyoscyamus, stramonium, sulphur, veratrum album, and veratrum viride.

In states of depression, aurum, actæa racemosa, ignatia amara, lilium tigrinum, pulsatilla, and sepia are those most frequently indicated. Special indications are as follows:

Aconitum.—Melancholia following excitation produced by fear.

The morbid state of the mind approaches dementia in lack of courage, confidence, and energy of character.

Moans and lamentations arising from the apprehension of her death being near. She becomes positive of the date of her death. Weakness of memory; loses the faculty of remembering dates. Expression of terror and imbecility in the countenance.

In mania accompanied with febrile condition. Fittful mood; at times in furious delirium, again in full possession of the mental faculties. Delirium, especially at night.

Actæa racemosa.—Melancholia following labor, a heavy

* "A Treatise on Medical Electricity," Althaus, London, 1870, p. 436.

† "Electrotherapie," Vienna, 1868, p. 208.

cloud of misery hangs over the patient. Simpson * reports a case which he calls "puerperal hypochondriasis." "A lady, the mother of several children, was twice the subject of the most painful mental despondency a month or two after delivery. On one of these occasions she was confined in London, and had the advice of several eminent physicians; but the disease took a very long and tiresome course, seemed to defy entirely all remedies, and gradually and very slowly terminated. On the last occasion on which the attack occurred this patient was confined under my care, and went home to England some weeks subsequently perfectly well. She returned, however, in about a month to Edinburgh, in the lowest possible state of depression, a perfect picture of mental misery and unhappiness.

"I tried many plans to raise her out of this dark and gloomy state. All failed. At last, fancying, from some of her symptoms and complaints, that there might be a rheumatic element in the affection, I ordered her fifty drops of tincture of *actæa* thrice a day. After taking one dose she refused to continue it, as the drug had a taste so similar to laudanum, and as all opiates had always made her worse. On being reassured that there was no opiate in the medicine, she recommenced, without any faith, however, in the results, as she had in a great measure lost faith in all remedial means. When I saw her next, some eight or ten days afterward, she was altered and changed in a marvelous degree, but all for the better. On the third or fourth day, as she informed me, the cloud of misery which had been darkening her existence suddenly began to dissolve and dispel; and in a day or two she felt perfectly herself again in gayety, spirits, and energy."

Dr. C. P. Hart † gives a case cured by *actæa*, five drops three times daily; the case was reported by Dr. A. F. Stobbs, who describes the symptoms as follows: "Soon

* Op. cit., p. 583 et seq.

† "Diseases of the Nervous System," 1881, p. 336.

after confinement she became melancholic. She imagined the whole world was against her, and that she would become insane and be sent to an asylum. She would sit and rock continuously, crying and sobbing, feeling perfectly helpless, and satisfied that her condition was beyond the reach of medical skill." Dr. E. M. Hale places great stress on the symptom of sleeplessness as a keynote, and gives also as characteristic symptoms, "She was suspicious of everything and everybody; would not take medicine if she knew it; indifferent, taciturn; takes no interest in household matters; frequently sighs and ejaculates; great apprehensiveness and sleeplessness."

Aurum.—Suicidal mania with dejected spirits. Religious mania; she howls and screams and imagines she is irretrievably lost because she has neglected some duty. Aurum is seldom indicated in the melancholia of females; Platina will more often be found suitable in such conditions, arising from disturbances of the sexual organs of the female.

Belladonna.—The wonderful effect of this drug over diseases of women extends equally to the mental symptoms arising from disturbances of the female genitalia. In its pathogenesis we find: foolish manner; immoderate laughter; she sings merry but senseless songs. Mania: she spits at those around her; bites, strikes, and tries to escape and hide herself. Delirium, which returns in paroxysms, first of a merry nature, afterward changing to rage.

Dr. H. H. Hofmann presents a verification of belladonna in puerperal mania.*

"The first case that came under my observation was in a primipara of nineteen years. She was attended by a midwife, and everything progressed favorably until the sixth day. She then became feverish, had a high pulse, glistening eyes, red cheeks; biting, tearing, and destroying everything about her, and not recognizing her mother or her hus-

* Transactions of the American Institute of Homœopathy, 1882, p. 390.

band. I administered one dose of bell. 200, which was followed in a very short time by her regaining consciousness and knowing those about her. She had six children after that, but never had another attack."

TREATMENT OF PHLEGMASIA ALBA DOLENS.

BY CHESTER G. HIGBEE, M.D., TACOMA, WASH.

In consulting, as I have, quite a number of books and journals in relation to the above subject, I am astonished at the small number of authors who have written upon obstetrics and gynæcology who do anything more than refer to the disease in a brief paragraph.

Some who mention it and speak of the uncertain pathology give no treatment whatever. Others recommend treatment so irrational that no intelligent physician of the present day would think of recommending it. As it is conceded that the disease usually occurs in patients who are weakened by some other disease, the fallacy of the old practice of bleeding is apparent. Blisters, too, though more rational, by no means do as much good as harm. The swelling and congestion may produce an anæsthesia in the peripheral nerves, so that a blister will do great harm before it is felt. The embrocations recommended by old-school authors were numerous and no doubt useful in many cases.

I believe the best authorities agree that the disease is of septic origin. To us this would give the key to the curative remedies. While we have a long list for the relief of the most *prominent* symptoms, there are but few that correspond to all the manifestations of the disease. I think that in this disease, as in some others, the best treatment is that administered before the attack. In other words, prophylactic. I find that many homœopathic physicians have never had a case, and others very few. This corresponds

with my individual experience. As we have under consideration only those cases that arise during the puerperium, our recommendation will apply only to such cases.

As prophylactic, we should have our patients under supervision during the whole period of gestation, and promptly check any departure from health at its onset. We should recommend such exercise in the open air as each can bear. This will give the tone and strength to the muscles and nerves that is so much needed at the time of confinement. Sitz baths, taken every day, followed by gentle friction, are useful in equalizing the circulation and preventing congestions. If there is nervousness, and dread of the approaching crisis, gelsemium given in the evening will quiet the apprehension, and induce sleep, if there is insomnia. If there is excessive pressure upon the superficial veins, bathe the parts with a lotion composed of arnica tinct., oil of sweet almonds, and alcohol. In applying any external application, rub from the extremities toward the heart. These are requisite means to use before confinement. A few years ago I attended a lady in confinement, and left her in charge of my assistant, and I left home to attend a meeting of this Institute. I had only met the lady once previous to the call for labor, and knew but little of her condition. About the end of the first week after confinement she was attacked with the first symptoms of phlegmasia, and it soon developed into a severe case. In answer to telegrams I hastened home, and had the satisfaction of conducting the case to a successful issue. In two subsequent confinements she had prophylactic treatment and no phlegmasia. During labor every possible means should be used to prevent laceration of any of the organs involved, and to secure immediate contraction of the uterus after removal of the placenta, thus diminishing to the minimum the danger of absorption of septic poison or germs.

Corresponding to all the indications after successful delivery, we know of no other remedy equal to arnica. It

will do as much as any other to relieve the taxed muscles and soothe the nerves. In case of laceration, whether or not an operation has been necessary, arnica is still indicated. If septic absorption is feared, arsenic alb. should also be given from the time of confinement. If premonitory pains are felt in the uterus and leg, the utmost care should be taken to secure rest, both physical and mental. The leg should be slightly raised and supported evenly, and be gently bathed with a solution of hamamelis.

The leg and foot should be kept warm, even to perspiration. If now fever ensues, aconite should be given in place of arsenicum. Hamamelis internally will also prove a valuable remedy. If, in defiance of all this treatment, the disease progresses, and the pain, swelling, and fever increase, the leg may be enveloped in a thick layer of cotton batting, or wrapped in flannels wrung out of hot water and frequently changed. Other remedies will have to be used as the symptoms change. Belladonna, rhus tox., apis, verat. vir., in addition to those above mentioned, will be at times useful. From the time of delivery, antiseptic vaginal injections should be used. Beef-tea and wine will be needed to support the system until the crisis is past.

As soon as the inflammation subsides, bandage the leg evenly from the foot to the thigh.

If abscesses form in the inguinal glands, or along the course of the lymphatics, freely open them and wash out the cavity with carbolized calendula water. To prevent the disease from extending from one side to the other, the patient should avoid any strain upon the leg not affected, and it should be frequently rubbed to promote circulation in the superficial veins.

If embolism develops, and the clots are transmitted to the heart or brain, a fatal termination is probable, and no remedies will avail.

THE PATHOLOGY OF MAMMARY INFLAMMATION.*

BY WM. C. DAKE, M.D., NASHVILLE, TENN.

Among the many diseases to which women are liable there exists scarce one which oftener confronts the medical man, or more frequently gives him trouble, than inflammation of the mammary gland. Occurring, as it does in the vast majority of cases, in women glorified and weakened by recent maternity, it exerts its baleful influence on two lives instead of one, destroying the rest and comfort and sometimes even the life of the mother, and cutting off the food supply of the child, endangering the one by reason of the inflammation and its results, and the other by change of diet or starvation. Thus it becomes doubly important as a subject of study. As a simple affection but little interest attaches to inflammation of this gland, other than belongs to all glandular structures; but taking into consideration the unusual liability to suppuration, we find a new and deeper interest in it and the dangers caused thereby. In the puerperal state the condition of the gland is such as to encourage inflammation, and to continue it till the formation of an abscess results. The irritation of sore nipples, the engorgement consequent upon impeded flow of milk through the ducts, colds,—in fact each and every change that affects the physical or emotional condition during lactation—may, and does often, cause inflammation.

Persons of a weak or scrofulous constitution are more liable to trouble of this kind, and the inflammation, once having begun, is more likely to have serious consequences; to lead to suppuration, to heal more slowly, and to leave more lasting effects, often injuring the gland beyond repair. But in practice we sometimes find women of the most robust constitution, and otherwise in perfect health, attacked by

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mammary inflammation, and suffering fully as much as the weakest of their sisters. In those who have once suffered, it is said, there is found a slightly increased tendency to inflammation.

In the undeveloped state of the mammæ they are not subject to inflammatory affections, except of traumatic origin. Only during lactation do we find any great or unusual tendency to inflammation, the vast majority of cases occurring during the first three months, and the tendency lessening steadily as the months go on until weaning-time, when an increased risk arises because of engorgements and lack of care. According to pathologists there are three varieties of inflammation of the mammary gland :

First. The subcutaneous.

Second. The glandular, and

Third. The sub-glandular.

First. Of these the first, or subcutaneous, when not extending into or causing the second, is by far the simplest, the least severe, and the least likely to cause serious trouble. It is usually a simple inflammation of the areolar tissues lying above the gland, and runs, when uncomplicated, much the same course as an inflammation in any similar structures, ending either in resolution or suppuration. When ending in resolution, which is rare, we find the redness, pain, and swelling diminish, the localized induration lessen ; the constitutional symptoms, if there were any, disappear ; nursing becomes less painful ; and shortly all traces of the affection vanish, leaving the breast as before the attack.

If, on the other hand, the inflammation does not subside, we find the engorgement of the tissues increasing, the tenderness growing greater, the inflamed area extending, nursing becoming more and more painful, or altogether impossible, the lancinating pains unendurable, and finally rigors or a positive chill ushers in the formation of pus.

Usually in the subcutaneous or superficial variety we find the abscess single, pointing near the nipple, running its

course rapidly, and ending by incision, or spontaneously discharging through the skin or into the ducts and through the nipple, leaving the gland itself in an uninjured condition. Frequently, however, it does not run this straightforward course, but the pus, making its way in the direction of least resistance, extending and deepening, opens into the gland, setting up true glandular mastitis; or by its involvement of the nipple, the tumefaction and interference with the free discharge of the lacteal secretion, it causes a general engorgement of the gland, and thus sets up a secondary inflammation, which speedily becomes active, leading to the formation of the true glandular mammary abscess and its consequent troubles.

Second. In the glandular variety of mammary inflammation, when occurring primarily, we find, usually, some circumscribed spot which is sensitive to pressure, speedily followed by a sense of heaviness and weight in the entire breast, with lancinating pains, and an engorgement of the vessels of the gland. Soon swelling begins, a flush appears, the temperature rises, and the inflammation is fully established. By the tumefaction the caliber of the ducts is lessened and the flow of milk diminished, and its retention aids in increasing the pain and spreading the inflammation. Inflammation of the gland ends either in resolution, which, alas, is too infrequent, or in suppuration. When resolution takes place we find changes most pleasant to see. The redness, pain, and swelling grow less, the induration gradually disappears, the flow of milk increases, and soon there exists only the remembrance of trouble, and a fear of it which lasteth long.

When it proceeds to suppuration the engorgement, the redness and sensitiveness, the pains and the interference with the flow of milk, the induration and the constitutional symptoms all increase. An intense restlessness tortures the patient, and soon a hard chill, or more than one, indicates the formation of pus. The swelling increases, the

skin becomes hot, red, and œdematous, fluctuation becomes apparent, increasing as the quantity of pus increases and draws nearer the surface. Soon, in the milder cases, the abscess points, and by incision, or by spontaneous evacuation, discharges its contents. Often the pus is discharged, mixed with the milk, through the ducts, and without external opening.

In the more severe cases there may be more than one point of discharge, leaving fistulous openings through which pus and milk escape for some time, exhausting the patient and doing infinite damage to the breast and its future usefulness. At times, even when the abscess is small and the symptoms mild, the discharge occurring early and the subsequent healing being rapid, we find, shortly after the case is apparently at an end, another abscess forming, which runs a course similar to the first, ending in discharge; and shortly, again another, forming an exhaustive succession, producing collectively a most serious effect on the patient's general health, and leaving the gland often permanently indurated and useless.

Occasionally the inflammation of the gland becomes chronic, lasting for weeks or months before suppuration takes place, and going through its various stages with extreme slowness, but with all the accompaniments of pain, swelling, and engorgement belonging to the more acute forms.

Though the usual result of abscess of the mammary gland is to impair its secreting power, it sometimes happens that the gland resumes its full function after a severe abscess. When this occurs, however, the tendency to a return of the trouble is increased.

Third. In the third, or sub-glandular variety, we find the primary inflammation seated in the deep cellular tissues underlying the gland. Owing to the dense mammary gland above, and the unyielding chest-walls below, the pain from the beginning is more severe than in the other forms of

mastitis. There is, at first, little but the pain to indicate trouble; if, however, the inflammation does not subside, but continues, there soon appears an elevation of the entire gland, the pain increases, becoming more and more severe, a diffused flush appears, and soon a chill shows the formation of pus. The constitutional symptoms become more distressing, the breast is elevated and seems to float on a sea of pus. The pus forms slowly, and, with extreme slowness, makes its way to the surface, frequently finding exit through several openings, leaving long fistulous tracts which heal but slowly and exhaust the strength of the sufferer.

Sometimes the pus escapes upward, passing into and through the gland. In this variety there is but little interference with the secretion, until the extreme sensitiveness prevents nursing, and leads to lacteal engorgement or the drying up of the milk.

The injury to the gland itself is often trifling compared to that left by the glandular form, and even after a long-continued suppuration, fistulous troubles, and great exhaustion, we may find another and luckier child thriving on the produce of the self-same breast.

THE ETIOLOGY AND SYMPTOMATOLOGY OF MASTITIS, OCCURRING IN CONNECTION WITH THE PUERPERAL STATE.*

BY J. B. GREGG CUSTIS, M.D., WASHINGTON, D. C.

Upon first receiving this subject from our worthy chairman I drew a long sigh, thinking that I had been assigned one of such magnitude and intricacy that I could treat it satisfactorily only by taking the time to consider it under many subdivisions, divided into firstly, secondly, and so on to twelfthly, at least, recounting symptoms by the score,

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and stopping occasionally to pay my respects to a few writers who have neglected the breast proper, while groping after some fashionable cause of the fever of their patients, such as malaria, cold, or neglect on the part of a nurse who had not received proper training; but, lo! upon looking into the recent literature of the subject, I found I was far behind, and that our German friends had greatly simplified the matter, claiming that, in the language of one of the latest, "Every case of puerperal mastitis is now known to be due to infection, or, in other words, is caused by bacteria." Or, as another states it: "Puerperal mastitis is secondary to disease of the nipples. These bacteria find their way into the milk, either through the ducts or through abrasions or fissures in the nipples, infect the milk, and thence the train of symptoms, which I will in part describe. If they enter through the ducts, we have a parenchymatous inflammation; if through fissures, the inflammation is of the phlegmonous variety."

You will all agree with me as to the simplicity of this theory; and the hints for treatment are so plain, and leave so much play for the ingenuity of the physician, that it is with regret that I tell you that I cannot either prove or approve it.

The least that we can say of it is that it is entirely unproved. And until these bacteria inventors or discoverers can offer better results from their treatment, based on their theory, we will hold to the old theory, which is more rational and more in accordance with nature, that reveals such wonderful foresight and beneficence in the anatomy and physiology of the breast of woman.

Should the wisdom which designed that the nipple should have just sufficient obliquity forward and outward, with a slight turn upward, so that it could be reached by the child in the most comfortable position for itself and the mother, have left the ducts so imperfectly protected that bacteria, even with all their modern improvements, could enter and

poison the fluid which is to give life and strength to the offspring which has been so conspicuously provided for?

For the sake of those who are not sufficiently progressive to accept this modern etiology, I will consider the condition presented for our study under four general heads.

First, Simple Subcutaneous Inflammation.—These cases may be accidental, so far as the puerperal state is concerned. Our observation leads us to believe that overheating of the patient, or of the breast, is a common cause. They may or may not be associated with disease of the nipple.

The symptoms are those of any small abscess, or of a boil. There is very little, if any, constitutional disturbance. It may be located in any part of the gland, but is most frequently found near the nipple.

It usually results in suppuration, with discharge through a single opening.

Second, Parenchymatous Inflammation, or Mastitis Proper.—In this variety the inflammation may be treated in the gland tissue, or in the connective tissue between the lobes of the gland.

It may occur at any time during lactation, but is most likely to arise within the first ten days after labor.

The principal causes are : exposure to cold, mental excitement, or blows upon the breast ; but the most common is the retention of milk, whether because of excoriated nipples, inability of the child to empty the breast, or neglect on the part of the nurse.

This retained milk causes a general congestion, which, if not relieved, will result in inflammation of the cellular tissue.

Again, we may have occlusion of some of the milk ducts, which will bring about the same result.

Now please note the symptoms and the order of their development.

First, a feeling of weight and fullness, with slight tenderness of the organ, and increased difficulty in relieving

the breast of milk; second, pains, shooting, darting, stitching, in any or all directions, especially when the child nurses; third, a slight chill, followed by fever. After this we see a redness appear in spots upon the breast. If not arrested, we have suppuration, with enlargement of the gland, and unless the patient's constitutional condition is of the best, fistulæ form, through which there is a discharge of pus and milk, the quantity varying in proportion to the extent of the gland involved, and the length of time taken for the abscess to reach the surface.

I believe that in this variety, this is the order of appearance of the symptoms in all cases. Is this the order of any septic process?

The first tangible sign of the septic process is the rigor, while in this form of mastitis, the most common and that generally referred to, the chill does not come for some hours, often not for some days, after the pain and tenderness. We must still maintain the possibility of such cases resulting entirely from engorged milk ducts. Treatment based on this theory is successful in allaying the inflammation and averting access, and it behooves us to combat this condition most vigorously, for if we are not successful, and the inflammation proceeds to suppuration once, we will have it repeated, and the fistulous openings referred to above will form.

I hope that those who follow will tell us how to cure them "right up."

Third, Inflammation of the Lymphatics of the Breast.—

This is not a common form of inflammation, and is due to the constitutional peculiarities of the patient. The exciting cause may be cold but most frequently the inflammation is due to the establishment of the proper function of the gland in a scrofulous patient, or one having a peculiar tendency to lymphatic inflammations.

The constitutional symptoms are severe chills, fever, rapid pulse, loss of appetite.

We differentiate the condition by the peculiarity of the appearance of the glands; redness appears on the surface in small spots, or streaks, which follow the course of the lymphatics from the breast to the armpit. It generally terminates in resolution, but if not, the abscess is superficial and rapidly heals.

Chronic abscess of the breast, or the cold abscess of some writers, is a lymphatic abscess developed in an old induration. It is accidental, so far as the puerperal state is concerned, and we will pass it by, as also erysipelatous inflammation, which likewise is accidental; and also the mastitis which arises during puerperal fever, which is metastatic.

Fourth, Sub-Mammary Inflammation, or Retro-Mastitis.—

I now ask your attention to this, the last, but most interesting, division of the subject.

This is the form in which most mistakes are made—mistakes which cause so much suffering to the patient, and so generally issue in the destruction of the function of the organ.

To understand this condition, we must glance at the general anatomy of the breast.

The gland is supported by two layers of fascia between which it yields to pressure.

While the fascia thus supports, it also firmly unites its several sections. In many cases the fascia forms a synovial bursa at base of the gland, which bursa separates it from the great pectoral muscle, the sterno-costal cartilages, and the ribs. The issue has the appearance of plicated laminae, instead of being smooth.

We recognize here the possibility of inflammatory condition in any or all of its varied forms. The inflammation is the result of the development of the glands under some abnormal or unfavorable condition which may be some more or less pronounced variation from the normal formation of the glands, or it may be cold from undue exposure of the breast.

My observation leads me to think that inflammation in most of these cases cannot be averted, though it can be controlled.

The symptoms of this form are very characteristic. Three or four days after confinement the patient is seized with severe rigors and sense of chilliness, with great thirst, dry mouth and rapid pulse, not unfrequently reaching 140 a minute. The head aches fearfully, as do the limbs also, and pains may be present in the abdomen, due to the rigor. This is followed by a severe hot stage, that lasts from two to nineteen hours; and this by a sweating stage, that brings speedy and gratifying relief. The patient makes no complaint of the breast.

At about the same hour the next day the symptoms are repeated, and again on the third day, unless the physician is successful in his efforts to subdue the inflammation. If he is not, the patient, after the second or third chill, begins to complain of the breast, and soon we have the unmistakable signs of mastitis, such as I have described above, which may end in suppuration; in which case the process will be tedious, and the time long before the pus reaches the surface. If the physician is successful in allaying this first attack of inflammation, and is not especially watchful, the same symptoms will recur after a few days.

As my time is limited, I will not repeat the symptomatology, but only call attention to the fact that many authors consider sub-mammary inflammation to be secondary to disease of the chest, or to a parenchymatous inflammation of the gland. I think this is a mistake; that indeed these are never the primary cause, but, on the other hand, when sub-maxillary inflammation is neglected, or badly treated, it may cause disease of the chest.

It has been my fortune to see many cases of this condition, and they have all followed exactly the course of development given above; and you will please note the general similarity of the symptoms to those of malarial or

intermittent fever, viz., chill, fever, sweat; with recurrence of chill on the following day at about the same hour. I have known this condition to be mistaken for intermittent fever, and because the physician did not examine the breast. The patient will not complain of it; in fact, may not complain until after the second or third chill, with its succeeding fever and sweat, though she will say the breasts are tender, "the result of the fever"; but the heat of inflammation is under the gland, which must be pushed aside, and examination be made as far under it as possible, and then we will discover the seat of the trouble.

Gentlemen, this is personal experience, and I would emphasize it. Not long ago I had a physician send me a message from Michigan, telling me how his patient, whom I was treating for retro-mastitis, contracted malarial fever, of which she did not exhibit a sign.

In the *N. A. Journal of Homœopathy* for December, 1887, you will find a paper on the Malarial Complications of the Puerperal State, in which the author gives the same symptoms that I have given above for the beginning of retro-mastitis, and tells us how frequently the symptoms of malaria show themselves in connection with the puerperal state, and how it is necessary, if treated successfully, to treat it with quinine. His cases, under this homœopathic(?) treatment, follow just the same course as retro-mastitis does without it: and here again we see the ease with which the two may be confounded. The course is that of malarial symptoms suppressed by quinine and returning at stated periods.

I do not deny the possibility of malarial poison attacking a woman in the puerperal state, and have called attention to it in another place, though I do doubt the frequency of cases which manifest themselves for the first time during the lying-in period. My experience is that all such cases show a malarial history previous to confinement, and my rule is to never diagnose "malaria" until I have carefully

eliminated the possibility of retro-mastitis and of septi-cæmia.

I will say, in closing, that if our bacteriologists can find any place for their favorites in mastitis, they must choose this latter form, and must find some other place of entrance for them than through the nipple or possible fissures.

Other forms of disease of the breast do not belong to us, for the reason that they are either secondary, metastatic, or accidental, as far as the period under consideration is concerned.

HYSTERECTOMY FOR UTERINE FIBROID, FOLLOWED BY THE REPEATED FORMATION OF RENAL CALCULI.

BY H. I. OSTROM, M.D., NEW YORK.

The case of hysterectomy here reported presents nothing of especial interest in itself. The tumor was an interstitial fibroid, and the uterus and both appendages were removed, the *serre-neud* being used to secure the pedicle extra-peritoneally. The most troublesome feature of the operation existed in the situation of the tumor. This, together with the uterus, was found firmly wedged between the sacrum and pubic arch, from which position considerable force was required to dislodge it. Even after atmospheric pressure had been removed, it was found necessary to elevate the uterus from the vagina before the tumor could be brought into the abdomen. More recently I have accomplished this stage of the operation with perfect ease by applying a pair of small obstetric forceps to the uterus, in the same manner that they are applied to the head in instrumental delivery.

The pedicle did not behave well, but gave no warning of trouble until the fifth day, when I first dressed the wound.

There was then found considerable sloughing and suppuration, for which nothing in the operation could account. The *serre-naud* and pins were removed on the eighth day, and the pedicle thereafter treated with pure balsam of Peru as an open wound. On the twelfth day, while removing a small piece of slough, I cut the uterine artery. This was, after considerable difficulty, secured with pressure forceps, which were left on for forty-eight hours. The healing progressed without interruption.

The feature of interest in this case that seems to me especially worthy of record was the formation of renal calculi, which began during convalescence and continued for several months, and for which nothing in the post-operative history offers an adequate cause.

The lady, about thirty years of age, gave no history of either renal or bladder disease. At the time of the hysterectomy she was in fairly good health, and her convalescence, until the tenth day, was no more eventful than has been mentioned. At that time a rather severe attack of cystitis developed, for which there appeared to be no reason, the catheter having been used for the first day only. The subsequent history of the case showed this condition to have been caused by the acid state of the urine, and by the mechanical irritation of numerous small stones which lay in the bladder, and which later passed through the urethra.

On the twelfth day after the operation there was a hard chill, followed by severe abdominal pain, located principally in the left ovarian region, but rapidly involving the entire abdomen. The temperature rapidly rose to 104° and the pulse to 160. There was considerable tympanitis and general tenderness. The body was bathed in a profuse perspiration, and the urine became almost suppressed. This condition lasted twenty-four hours, all the symptoms, with the exception of the temperature and pulse, gradually disappearing. These remained abnormal, the temperature

for two days ranging between 101° and 102° , and the pulse rarely falling below 110.

At this stage, and until later, when attention was directed to the kidneys, and the paroxysmal nature of the attacks was demonstrated, the group of symptoms strongly suggested septic poisoning, and gave rise to anxiety lest the sloughing pedicle was the cause. On the third day, that is the fifteenth after the operation, a somewhat similar attack developed. The pain, however, was more severe, running up to the left kidney, and down to the labia, where it finally settled, causing acute suffering. After the second attack, large quantities of calculous matter was passed with the urine, sometimes giving rise to urethral pain, but not constantly, for there would be found quantities of minute calculi on the labia, when not preceded by symptoms indicating their passage. Some of these were so large as to favor the belief that they were formed outside of the urinary tract, but that at least some proportion had their origin in the kidneys there is no reason to doubt. The severe renal pain, and the soreness that remained, over first the right kidney, and then over the left, clearly indicated the primary source of the disease. After the third attack the renal colic returned about every sixth day; the uric acid, however, continued to be deposited in slightly diminishing quantities. At no time was there any blood in the urine, but there existed a considerable proportion of pus and albumen.

During the entire period of this excessive formation of uric acid, the patient's convalescence proceeded without interruption. The wound healed perfectly, between the attacks her appetite was good, and from day to day her strength returned. The high fever, which was quite a rare feature of renal colic, no way retarded recovery. It is now six months since the operation. The attacks return every three or four weeks, but are much less severe, and do not last as long as formerly. In other respects this lady is perfectly well, and is able to walk several miles without undue fatigue.

The treatment that I adopted seems to have produced more than temporary relief. In the way of medicine *lycopodium* was followed by a more decided improvement than any other remedy given. Washing out the bladder with a salt solution, my formula being

Common salt,	3 i.
Carbolic acid,	gtts. xx.
Warm water,	pints i.

was invariably followed by marked relief of the vesical irritation: This has now for some time been discontinued. In the early stages of the attacks I was on several occasions strongly inclined to cut down upon the kidney, for I could not explain the recurring chills and high temperature save upon the hypothesis of suppuration. But the recovery from each attack was so prompt and complete that the operation was deferred until the absence of any more decided symptoms excluded the probability of such a complication.

LACERATION OF CERVIX UTERI.

BY F. S. FULTON, M.D.

The first mention which we have regarding this most important lesion was made by Dr. James Henry Bennett, of London, about forty-five years ago.

Previous to that time mothers had conceived and borne children, been torn and lacerated by at times competent, often by incompetent, midwives, tormented afterward by outraged nature and well-intentioned but ignorant physicians, been seared with the cautery, burnt with pastes and escharotics, suffered many things of many physicians, and gradually weakened, and at last fell victims to exhaustion, epithelioma, or too quickly developed phthisis. While Dr. Bennett recognized the fact that a cervical lesion existed,

he did not fully appreciate its true nature, or the necessary treatment. He says: "Sometimes the cervix is not so much dilated as burst open, and then the lacerations, radiating from the center, divide it into segments, which can be traced both with the finger and the eye at a subsequent period. Thus it is that the foundation is laid for still more serious diseases. Instrumental and difficult labor is very frequently accompanied by laceration of the uterus in the absence of any morbid state. In such cases the cervix generally presents deep fissures caused by the lacerations. The laceration or abrasions may heal in the course of a short period, under the reparative process set up in the uterus after labor. On the other hand, under the influence of a general febrile condition, or of local inflammation, and often from the operation of causes which it is impossible to appreciate, these lesions, whether slight or severe, do not heal, and thus a confirmed inflammatory ulceration of the cervix uteri becomes established."

While recognizing the lesion and its cause, he suggested no treatment other than local applications. He also made the mistake of confounding the raw, eroded mucous surfaces, attended, as they uniformly are, with cervical and generally uterine hyperplasia, with ulcerations, which are of exceedingly rare occurrence.

In 1862 Dr. J. Addis Emmet accidentally recognized the importance of this lesion, and originated the operation for its relief which has since been styled by different authors, "Emmet's operation," "Hystero-trachelorrhaphy," "Trachelorrhaphy," and "Tracheloplasty." In 1869 Dr. Emmet described the operation in a paper on "Lacerations of the Cervix Uteri," read before the Medical Society of the County of New York. In 1871 he read a second paper before the same society upon the subject. This paper received a very wide circulation, being translated by Dr. M. Vogel and published in Berlin in 1875.

As even yet Dr. Emmet's views were not fully under-

stood, he prepared and read a third paper in 1876 upon "The Proper Treatment of Lacerations of the Cervix." This paper, together with the preceding, was translated and published in Berlin. Following this were several articles in the medical journals upon what was then a new operation.

To Dr. Emmet belongs the honor of introducing to the profession an operation which has probably done more to relieve the sufferings of women than any other surgical procedure known to gynæcology.

Since its first introduction very little modification has been made in the original operation. As in all operations or new methods of treatment of real merit, it was at first decried as irrational and lacking the virtues attributed to it. Later, as some of the more venturesome surgeons adopted it and met with, sometimes, startling success, it became the fashion, and was lauded to the skies. Every woman in whose cervix the slightest nick could be detected was induced to submit to the operation, with little regard to any possible connection between her sufferings and the cervical lesion. No doubt, that in this stage of the operation, many were performed of which there was no need. But every operation of real value goes through the three stages of depreciation, over-valuation, and later, as time and experience determine, takes its true place among the remedial procedures of surgery. While trachelorrhaphy is not done now as often as formerly, no doubt from greater knowledge of its pathology, consequence, both nervous and textural, and indications calling for its performance, much better results are obtained. Of these we will have occasion to speak later.

Etiology.—The lesion is most apt to occur in primiparæ, whose cervical tissues yield with difficulty to the dilating force of the head and amniotic fluid. In multiparæ the os naturally is patulous, while in those who have not borne children the inelasticity of the tissues resists the dilating force of the uterine contents, and remains tightly drawn

together until just preceding delivery, greatly favoring laceration.

At such times the tissues will be torn, even in what would otherwise be a natural delivery. Of the different causes which operate to produce this lesion, rapid and difficult deliveries rank among the foremost. The cervix cannot relax and mold itself with sufficient speed to meet the necessities of the tremendous expulsive action of the uterine and abdominal muscles. The amniotic sac is ruptured spontaneously or by the accoucheur in an early stage, the uterine contents are forced rapidly down through the parturient canal without time being given for the parts to adjust themselves to the passage of the child, and laceration occurs.

Dr. Emmet's statistics show that in his cases slow and tedious labor has been more frequently the cause, 30 per cent. of his cases being due to this. But, although contrary to their present evidence, he says he fully believes that more extended investigation will prove that rapid and difficult delivery is more often responsible. Careless, and oftentimes needless, instrumentation is another most productive cause. Application of the obstetric forceps within or above the superior straits is an operation attended with danger, even in the hands of experienced obstetricians.

Oftentimes, by the power which one gains over the movements of the head, and his greater ability to guide it and to favor by slight rotation, flexion, or extension, the stretched and rigid tissues of the cervix and perineum, lacerations can be prevented; but many physicians, and we fear the practice is growing, after having become accustomed to the use of instruments, apply them quickly, as soon as there is any delay in the pains or progress of labor, often from merely selfish motives, preferring to subject their patient to the risks of laceration, with its subsequent evils, to spending a few hours in the lying-in room or depriving themselves of a night's sleep. Such instrumentation is

criminal in the extreme. When the forceps are properly applied in cases which demand instrumental interference, we believe that the cases when lacerations occur in excess of what would have resulted without their use, are very few indeed. But statistics make evident that to hurried and careless instrumentation are due many serious cases of laceration of both the cervix and perineum.

In the country, where these lesions are little thought of, and very frequently not recognized, or, if diagnosed, not considered of sufficient importance to warrant operative interference, it is a matter of not so much importance to the accoucheur if he lacerates his patient by needless violence, as it is not apt, afterwards, to redound to his discredit.

In the city, among the wealthy, it is quite different, though this accident is common among them; but among the poor who are compelled to accept the city charities, the frequent lacerations, which are generally bilateral, and, when forceps are known to have been used, of an extended character, coupled with the history these poor unfortunates present, make it evident that to instrumental interference during parturition must be attributed many needless and serious lacerations. Another cause to be found in the lying-in room is the persistency and haste which some physicians insist upon displaying in forcibly dilating with the finger the cervical tissues during the presence of the pains. No doubt, in certain cases of rigid os, or labor delayed for some cause in the first stage, this is necessary; but it is not imperative that the moment the mother feels the onset of the true labor pains, the attendant should inaugurate a ceaseless attack upon the relaxing tissues of the cervix; nor is it in the least essential for the physician to administer heavy doses of ergot to stimulate a uterus which is laboring as hard as possible, until it suddenly expels its contents at the expense of a serious tear which might have been avoided had time been given for the yielding cervix and

perineum to have accommodated themselves to the enlarged diameters of the cranial vault.

Dr. J. A. Reamy, of Cincinnati, considers the use of the fingers and ergot as of greater injury in the production of lacerations than are the forceps; while Dr. A. McDonald, in the *New York Obstetrical Journal*, says "that meddling application of obstetrical fingers in hurrying dilatation of a slow cervix, or in forcibly pushing the neck over the occiput during a pain, is the most frequent cause of cervical lacerations." It is a fact which is not always recognized that abortion, even at an early period, is capable of producing a serious lesion of this character. Dr. Emmet says that in every case where criminal abortion is acknowledged or can be proven, laceration has resulted.

In severe cases of ante flexion, where the flexure occurs at the os internum or below, and persists during the period of gestation, a laceration of one of the lips is apt to occur from unequal pressure being exerted upon one lip by the dilating head and amniotic sac. In these cases the posterior lip is most apt to suffer, as it affords the greatest obstruction to the passage of the cranial vault and enclosing membranes, by lying directly across what must be their channel of exit. Cases also of long-standing cellulitis, which have resulted in binding the cervix firmly to the pelvic walls, thereby materially interfering with its descent and movability, particularly if it be found necessary to resort to the application of forceps, offer conditions which strongly predispose to oftentimes extensive lacerations.

Frequency.—As we have indicated, this lesion is of very frequent occurrence in first labors. It is scarcely possible for delivery to occur without some, great or small, nick in the cervix resulting. Very many, by cleanliness and quiet, heal spontaneously, showing afterwards no trace of any previously existing lesion, or if the cleft be extensive and in proper location to favor spontaneous union, the healing may leave behind it a band of connective tissue, cicatricial

in nature, which not infrequently contracts, causing more or less cervical deformity. This condition is most apt to be found either when the laceration occurs in the anterior or posterior lip. Emmet says that at least one-half of the women who have borne children have cervical tears of greater or less degree. Dr. Pallen makes the statement that 40 per cent. of the women who suffer from uterine disease have laceration. Goodell asserts that about one woman in six, who suffer from uterine disease, has an ununited laceration of the cervix. Mundé says that out of 2500 parous women he found that 25 per cent. suffered from this lesion, and that 50 per cent. of these were of a nature serious enough to demand operative treatment, making, according to his statistics, only about $12\frac{1}{2}$ per cent. of all parous women who would require this operation. I have but little doubt that, as the operation assumes more and more its rightful place in surgery, and the detection of the lesion becomes more frequent, through greater knowledge, and its evil results better known, this estimate will not be found too large.

Pathology.—The proper pathology of laceration of the cervix cannot be understood unless the normal process by which the enlarged uterus, after parturition, returns to its wonted size be kept constantly in mind.

The cervical rent exerts a very great influence against the proper involution of the organ. The uterus and appendages become lessened in size immediately after delivery, but instead of involution being carried on until the uterus again possesses a length of from two and a half to three inches, with a proportionate diameter, the process is slow, and at a certain point ceases entirely, leaving an enlarged, boggy uterus, which possesses no inherent power, unaided by art, to ever again assume its rightful proportions. After this the probe will discover that the length of the uterine canal is from two and a half to three and a half inches, according to the amount of laceration and consequent

hypertrophy. No doubt that this is due to a certain extent to the reflex nervous irritation brought about by the unhealthy condition of the cervix reacting upon the highly sensitive nerves imbedded in the tissue; but probably the greater reason is the obstruction to the blood current, both in the arterial and venous system, offered by the eversion of the lips. The uterine artery, which furnishes almost the entire blood supply in the neck and body of the uterus, is a branch from the anterior branch of the internal iliac. It runs obliquely downward from outside the ovary between the two folds of the broad ligament, in close connection with the ureters, to the junction of the peritoneum and cervix, from which point it turns upward, and with numerous windings and doublings runs upward along the uterine body to the fundus, where it enters the muscular structure of the organ and is lost in minute ramifications.

The circular artery of the cervix is given off at the lowest point of the uterine vessel, and runs at right angles to the main trunk around the cervix on either side, anastomosing in front and behind with its fellow of the opposite side. It is this artery which offers the only danger of hemorrhage, and which is the one not infrequently severed in the repair of deep lacerations extending to or beyond the cervico-vaginal junction. The other branch of the uterine artery of importance is the ovarian, which proceeds outward near the fallopian tube and anastomoses with the ovarian, or spermatic, which is a branch from the abdominal aorta, and furnishes the blood-supply to the ovary through a system of numberless reduplications and offshoots upon the posterior aspect of that gland.

The venous supply consists in two large plexuses, which follow the course of the arteries and are termed, respectively, the "Plexus uterinus" and "Plexus pampiniformus." The former accompanies the uterine artery, and carries the return current of blood from the uterus and broad ligament downward, and empties ultimately into the internal iliac

vein. The plexus pampiniformis accompanies the ovarian arteries and empties, as does the spermatic in the male, on the left side in the vena renalis, and on the right in the vena cava. While the veins are in the substance of uterus and broad ligament, they are very poorly supplied with valves, allowing very easily of a damming back of the blood from mechanical obstruction. When the laceration occurs, and by the force of the surrounding structures and the increased weight of the uterus the lips of the cervix are reverted, it produces a natural constriction of the venous channels, particularly those which return the blood from the body of the uterus, and which emerge from the uterine body and conjunction of the broad ligament just at the point where the stretching process produced by the eversion of the lips is most markedly felt. By this natural means the blood is forced back into the uterine body and appendages, producing a condition of plethora and consequent hypertrophy. When the patient begins to again assume her household work after delivery, this enlarged uterus drags on the pelvic structures; the ligaments, not yet hardened after their great distension, cannot resist the strain. Sooner or later the organ will prolapse to a greater or less extent, the ligaments become weakened, flabby, and no longer give the needed support. Cellulitis is generally established. It may occur immediately, before the patient has left her bed; not infrequently it manifests itself so quickly as to seriously interfere with the proper performance of nursing, as the presence of cellulitis consequent upon a cervical laceration has a direct tendency to suppress the secretion of milk.

It is claimed by Emmet that you can, not infrequently, ascertain at which delivery the laceration occurred, by finding out after which delivery the mother had been unable to nurse her child.

As a consequence of the cellulitis and the phlegmonous deposit usually occurring in one of the broad ligaments, bands of adhesions are formed, which, by ultimately con-

tracting, draw the uterus over to one side or the other, or backward. When these occur it is very difficult, often impossible, to restore the uterus to its normal position. When this does not happen, the increased weight of the uterus not only presses it down, but, as the cervix is the fixed point and the fundus movable, retroverts it. Anteversion and antelexion also occur, but more rarely. In the *American Journal of Obstetrics and Gynecology*, for July, 1883, Dr. Van de Warker reports thirty-one cases, in which the uterus was retroverted in twenty-two, prolapsed in seven, anteverted in one, and normal in one.

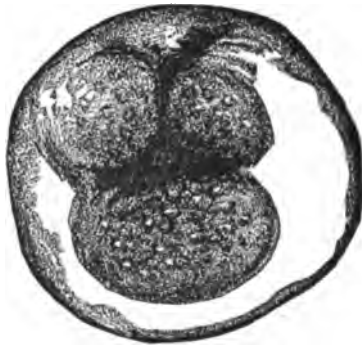


Fig. 1.*

When the laceration occurs anteriorly or posteriorly, it is not infrequent for it to heal spontaneously; but when the laceration is lateral, particularly if bilateral, the lips have a natural tendency to eversion. The main ligamentous attachments are the vesico-uterine, extending forward to the bladder, the recto-uterine, passing between the uterus and rectum, and the broad ligaments, extending laterally to the bony walls of the pelvis. If one will closely consider the manner in which these ligaments are attached to the uterus, and their *modus operandi*, it will become at once obvious

* Figures Nos. 1 to 6 and Nos. 30 and 31 are from Helmuth's *Surgery*, and appear through the courtesy of Mr. F. E. Boericke, Philadelphia.

why eversion of the lips must almost necessarily follow bilateral laceration. As a result, the delicate, sensitive membrane of the cervical canal is exposed to constant friction against the vaginal walls, an inflammation of the endotrachelian membrane is established, the Nabothian glands become congested and pour out a profuse, sticky, often acrid leucorrhœa, which irritates the parts and produces a condition of profound anæmia. The entire cervix implicated in the laceration undergoes septic hyperplasia, by which the parts are rendered prominent, boggy, and soft, as is indicated in Fig. 1.

Nature endeavors to repair the damage and to again restore the normal outline of the cervix by filling in the bottom of the cleft with a large amount of cicatricial tissue, which is hard, and at times almost horny in consistency. For this reason, unless careful examination be made, an extensive laceration may be overlooked. It is this cicatrix which, by pressure upon the nerve of the cervix, causes so much reflex nervous disturbance. The cervical glands become stopped up and cystic, presenting those small cysts, containing a thick, jelly-like secretion which is so often present in an everted surface.

At times this cystic degeneration and hyperplasia result to such an extent that it has been mistaken by some most eminent gynæcologists for malignant neoplasms. Fig. 2 well represents this simulation of carcinoma.

Regarding the tendency of these new formations to appear at the site of old lacerations, there can be but little question.

As is well known, epithelioma is apt to develop wherever there is any constant irritation perpetuated for considerable time. A sharp tooth will cause epithelioma of the tongue; the constant smoking of an old clay pipe will develop one on the lip; epithelioma of the scrotum in chimney-sweeps, from the irritation caused by the accumulated soot, is not uncommon; an obstinate eczema or psoriasis of the breast

will not infrequently terminate in carcinoma; the same holds true regarding the cervix. The constant friction of the everted and eroded surfaces, which naturally tend to cystic proliferation, against the vaginal walls; the irritation, and often bleeding, occasioned during coition, together with the other sources of local disturbance to which the part is subject, are quite sufficient to account for its not infrequent development in cases of severe laceration, and go far toward proving that they stand to each other in the relation of cause and effect. Sterile women, or those who have born no children, rarely suffer from cancer of the

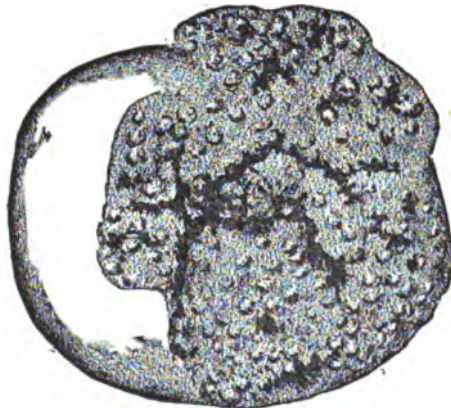


Fig. 2.

uterus, while in those poor unfortunates whom this terrible malady attacks, it is exceedingly rare not to find, on removal of or in the diseased tissues, the nick of an old laceration. Dr. Beale reported in the *New York Medical Journal* of July, 1883, that he had had seven cases of uterine carcinoma, in all of which there was a pre-existing laceration. Dr. Goodell, of Philadelphia, says he believes that the operation for laceration prevents the development of cancer, as the more children a woman has, the more liable was she to carcinoma of the uterus, and that

when they did develop it was not infrequent to be able to see within them the notch of an old laceration. The danger of the occurrence of this most lamentable complication is greatly increased in those women whose family history present cases of cancer in any of its developments. In these women a bad laceration, or even a slight one, ought never to be allowed to go unrepaired, for fear that at any time a benign erosion may assume a malignant type, and by rapid proliferation, hæmorrhages, and gradual exhaustion terminate a life which might, by timely surgical interference, have been spared.

(*To be continued.*)

CORRESPONDENCE.

SAN FRANCISCO, May 24, 1889.

Editor HOMŒOPATHIC JOURNAL OF OBSTETRICS:

Dr. H. H. Crippen, of San Diego, Cal., in his admirable article on Insanity of Pregnancy, truly remarks that Dr. Conolly was not the first one who recommended the "non-restraint system" in the treatment of mental alienation, as Dr. Hill, of the Hanwell Asylum, carried it out about 1837. Now Pinel, the great French alienist, born 1745, died 1826, may be considered the first allopathic physician who carried out humane treatment for lunatics. In my office hangs a picture, where, to the astonishment of the nurses, he commands to have the chains removed from the patients; and in the American Cyclopedia it is said of him: "The improvement in the condition of the insane was the object at which he especially aimed, and the number of cures he accomplished astonished the profession, and the method of treatment he introduced has been adopted in all civilized countries."

We may excuse allopathic physicians, since they do not read the "Organon," but I think Samuel Hahnemann was one of the first, if not the very first, who preached the non-restraint doctrine. §§ 229-230 of the "Organon" are full of glorious hints for the treatment of insanity, and in § 229 we read: "*The physician and attendant should always treat such patients as*

if they regarded them as rational beings." Let us claim justice for the father of homœopathy, or at least from homœopathic writers, and let us urge over and over on every disciple of Hahnemann to read prayerfully a paragraph in our homœopathic Bible before retiring to rest.

Fraternally,

S. LILIENTHAL, M.D.

EDITOR'S TABLE.

The obstetrical clinic at Vienna is reported closed for the present on account of an epidemic of puerperal fever. Some time ago Professor Straus, the director of the clinic, reported to the authorities that a new building was needed on account of the faulty situation of the clinic; but this was refused. After thirty deaths, due to puerperal fever, their eyes are opened to the danger of the old building, and it has been closed for an indefinite period.

A change has been made in the Paris School of Medicine by which the chair of obstetrics and diseases of woman and children takes the title of "obstetrical clinic." The former professor of obstetrics, gynæcology, and pædiatrics, M. Tarnier, is elected professor of the obstetrical clinic.

M. Budin (*Le Progres Medical*), in lecturing on "The Hæmorrhoids of Pregnancy," states that in the case of a woman during child-birth, who had inflamed and strangulated hæmorrhoids, he was obliged to administer chloroform in order to obtain the reduction of the tumors. From the first inhalations the pain disappeared, and the hæmorrhoids were reduced without causing suffering, although the patient was conscious of what was done to her and of all that was going on around her. Many French authorities have previously denied that an analgesia can be obtained with chloroform which will permit the execution of some minor operations without the suppression of consciousness, and this admission, made by so prominent a teacher as M. Budin, is worthy of record.

M. Budin is also the author of a little epitome of "the course to pursue in shoulder presentations" (scapula-læva posterior and anterior, right or left).

2. DURING LABOR.	I. DURING PREGNANCY.		Cephalic version by external maneuvers.
	I. Membranes intact.	A. Dilatation non-complete.	(a). Cephalic version or pelvic version by external maneuvers.
		B. Dilatation complete.	(b). If the attempts at version fail: wait.
	II. Membranes broken.	Rupture the membranes, perform podalic version by internal maneuvers.	
		A. Dilatation non-complete.	(a). Version by external maneuvers.
		B. Dilatation complete.	(b). Combined version of Braxton Hicks.
			(c). If one does not succeed, wait dilatation.
			(d). If the dilatation is tedious, attempt artificial dilatation.
			(a). Podalic version by internal maneuvers.
			(b). When this is contra-indicated, embryotomy.

* * *

The *routine* employment of ergot of rye as a parturifacient is receiving the condemnation that we have urged. Prof. Woodward of Chicago says: "Secale is one of our poorest hæmostatics in uterine hæmorrhage, and its use is generally followed by some puerperal disorder. Belladonna or ipecac is better." On the other hand, the allopaths are arriving at the same conclusion, for Prof. Desrosiers (*L'Union Médicale du Canada*) claims: "The employment of ergot as an accelerator of labor constitutes one of the grossest errors of therapeutics."

* * *

Parganime (*Médecine russe*, No. 31, 1888) places before us a claim to have discovered a new symptom of pregnancy. This is found at a very early period of gestation, and, being present before any other objective symptoms can be discovered, will be a valuable diagnostic sign, if it has the value attributed by its discoverer. The new symptom consists in the pulsation of one of the uterine arteries. In order to feel it, it is necessary to make

with the examining finger an exploration of all the inferior segment of the uterus, near the region of the internal os, allowing the finger to remain some seconds at each part of the uterine circumference.

The palmar surface of the other hand is applied to the abdomen, as in bimanual examination. It is open to doubt whether this symptom can be given the prominence ascribed to it by the author as a diagnostic sign. It would certainly seem more plausible that pulsation of the uterine artery could be produced by any factor capable of interfering with the normal circulation of the uterus, that it might be present in certain forms of uterine myomata, as well as in pregnancy.

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Professor Frommel, of Erlangeⁿ, Bavaria, requests the announcement that he desires to receive from all authors of obstetrical or gynecological treatises (since 1888) a copy of their work. Each one will be given an analysis in his forthcoming "International Annual Account of Gynecology and Obstetrics."

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Exalgine is the new pet of the "regular." M. Dujardin-Beaumetz was the first to present this new drug to the profession. It is drawn from the methyl derivatives of the amidogens, and possesses the euphonious chemical synonym of *orthomonomethylacetanilide*. We have already drawn attention to the use of antipyrine as a remedy for dysmenorrhœa, but hardly was the ink dry when exalgine was extolled as another new remedy for the same condition. Dr. P. Ménière, editor of the *Gazette de Gynécologie*, has been making experiments in this direction, and in three patients affected by neuralgic crises at the menstrual period, has obtained more complete and more rapid relief than with antipyrine, which had been previously prescribed for some months.

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The third congress of the German Society of Gynecology was held on the 12th and 14th of June, at Freiburg. Among the many eminent men who were present were the following who delivered addresses: Kaltenbach and Fehling, on "Auto-infec-

tion"; Werth, on "Tuberculosis of the Genital Organs"; Werth and Winter, on "The Treatment of Extra-uterine Pregnancy"; Wiedow, on "Pelvic Abscess"; Sonntag, on "Plastic Operations on the Genital Organs"; Hoeschler, on "The Ovary in Uterine Fibromata."

GOLDEN GRAINS.*

—Aching pains in the limbs; limbs are useless, with pain in left groin; falls down in a dead faint at monthly illness: *Magnesia carb.*

—The words "contagious" and "infectious" should give way to Pettenkofer's designations, "exogenous" and "endogenous," as the former are much less precise in defining the origin of disease.

—"The heart at times seems to be suddenly pulled up when going to sleep and then let go again, and this startles her," is a symptom reported as disappearing while taking *mag. carb.*

—This reminds one of a similar symptom under *magnesia mur.*, "sensation as of a ball rising from the stomach into the throat," which occurs in connection with uterine spasms, and with pain in the thighs when sitting.

—Apropos of the antiseptic properties of the perchloride of mercury, the recent researches of Steffek have shown that no number of douches with a solution containing this drug will render the vagina aseptic at the end of pregnancy. To effect such a result it is necessary to scrub vigorously with two fingers, not only the vagina, but the inside of the cervix, while a douche of at least a litre is being used. Even this produces only a momentary effect, unless it is followed up by the use of douches at frequent intervals.

—In rebellious children affected by intense photophobia the in-

* Included under this heading are brief original written communications and sayings of practitioners, and practical items translated, generally the work of Dr. H. H. Crippen, by whom the title is suggested, and which gains appropriateness from the fact that he is a resident of the Golden State.

stillation of collyria of atropine or eserine can be replaced with great advantage by the same drugs incorporated with vaseline in the same proportions. Instillations of liquid are instantly rejected by the spasmodic contraction of the lids, while the oily preparation adheres longer.

—In fibromata of the neck of the uterus, complicating labor, *fibromata prævia*, there are several indications as to the conduct to be assumed. If the tumor is pedunculated, cut the pedicle and allow the accouchement to follow its course. If the tumor is sessile, or if it occupies Douglas's cul-de-sac, try to push it back above the superior strait by pressure made during the intervals between the contractions. By this means, one sometimes succeeds in relieving the pelvis of the fibroma which obstructs the passage of the child. If one cannot succeed in this, wait ; the efforts of nature sometimes produce a reduction that the obstetrician can not obtain. Finally, if the obstacle persists, if delivery is impossible, perform Cæsarian section to save the child and the mother.

—The date of delivery marks a change in the receptivity of women for the contagious diseases. The pregnant female is *less*, and the puerperal female is *more*, liable to contract these affections than other individuals are, when exposed to contagion.

—In the differential diagnosis of scarlatina puerperalis the following points distinguish it from true scarlatina : The absence of the prodromata of scarlatina ; the absence of throat symptoms ; the moderate temperature and the moderate amount of constitutional irritation ; the history of the development and decline of the eruption, and the character of the desquamation, which is apt to be in large scales and strips.

—Rapid emaciation of throat and neck in children: Nat. mur.

—The children which contract diphtheria in its worst form are often of tubercular diathesis.

—During child-bed she has no will to make water: Hyosc.

—The catarrhal conjunctivitis of very young children often has its origin in a prolonged sojourn in damp habitations. The first step toward cure then will be removal to a dry atmosphere.

—In these cases of catarrhal conjunctivitis from exposure to dampness, where the lids are swollen, the conjunctiva very red and thick, with a white flake-like secretion (even if the case has run for some time) the remedy will be aconite.

—As one gains experience one learns more and more to rely on the touch rather than on the sound. One then becomes convinced that the use of the sound ought to be surrounded by every exigency of safety; that it requires a very delicate manipulation and vigorous *aseptic* precautions. Its use should be limited to cases of absolute necessity; in all other cases one can become an expert in vaginal touch, and especially can we supersede its use by the employment of bimanual examination.

—During pregnancy the patient is disturbed between twelve and three o'clock at night by urging to urination: Aconite.

—M. le Prof. Laramée (*L'Union Med.*) observes that convulsions are more frequent at the beginning of scarlatina than at the *début* of any other eruptive fever. Ordinarily the convulsions are in direct relation with the elevation of the temperature; with the child, the convulsive seizures replace the delirium that one remarks more often in adult cases.

—Aching pain in the abdomen, during pregnancy, every night after going to bed, relieved by getting up and moving about: Conium mac.

—Antipyrine having failed our old-school friends in typhoid fever, they are now essaying it in gynæcology and obstetrics. Dr. Windel (*Med. Chir. Rundschau*) recommends antipyrine in menstrual colic. He has tried it in these cases as an enema in 1.40 gramme doses, with favorable results in many cases. Prof. Desrosiers has also obtained good results with antipyrine in post-puerperal pains (after-pains). "It does not expose to hæmorrhages and can be administered shortly after deliverance" (*L'Union Med.*). The dose employed is fifteen to twenty grains, repeated at the end of an hour and a half if necessary.

—Menses bright red, with pain in the pelvis as if screwed together: Causticum.

—Among the causes of sudden death in the puerperal state Dr. Auvard counts the following as the most frequent: (a) Pulmonary embolism; (b) entrance of air into the uterine veins; (c) syncope; (d) shock; (e) hæmorrhage. Of all this series of causes only the first three, properly speaking, produce sudden death, unforeseen, which strikes the woman in a state of apparent good health; in the other cases the obstetrician is always more or less able to foresee a possible fatal termination.

—Menses too profuse, with repeated paroxysms of icy coldness over the whole body : Silicea.

—M. Unger has reported observations on seven cases of nephritis consecutive to varicella. The albumen appeared from six to twelve days after the vesicles became desiccated. These observations are divided into three categories.

In the first category of facts there are no general disturbances, no fever, only a little albumen in the urine, which contained also some degenerated epithelial cells and colloid casts.

In the second category is noted a little fever (100.4° to 101°), nervousness and ill-humor, some stomachal pain. The urine is diminished, has a coarse deposit, grayish or yellowish; in this is found a great quantity of degenerated kidney epithelium, hyaline and granular casts, and white and red cells. The albuminuria is notable.

In the third category, which only includes a single case, the fever attained 103° , and was accompanied by pain in the region of the kidney, by dysuria, by œdema of the face and ankles, by vomiting, and by dyspnœa. The urine was scanty, sanguinolent, with a gelatinous brownish deposit, containing red blood cells in great number, granular casts filled with blood corpuscles and a great quantity of albumen. All the patients recovered well.

—Morning sickness of pregnancy, never amounting to vomiting, *with faint sickish spells during the forenoon* : Sulphur.

—Among the remedies that we are prone to overlook in a search for a prescription that will cover the totality of symptoms of a gynæcological case, one of the most valuable is natrum mur. On first thought, however, one would say "no danger of

confusion," for the nat. mur. woman presents a clear picture of drug symptoms : the anæmic appearance, the melancholic and easily angered temperament, the nervous weakness, the palpitation of the heart on least exertion, the great dryness of the mucous membranes and skin, the hyperæsthetic spine, the scanty, delaying menses, and the functional derangements of the sexual system, perhaps even prolapsus uteri, all these are certainly unmistakable guides. But many other remedies touch upon these same points and serve to lead us astray.

First of all we must distinguish the mental state of nat. mur. from that of causticum, pulsatilla, sepia, and stannum ; all have melancholia, but with shades of difference. Thus causticum has great sadness before the menses, with tendency to look on the dark side of everything. The distinguishing feature in this, however, is that the melancholia is characterized by an anxious state ; the patient is full of fears for the possibilities of the future. Not so natrum mur. The weeping mood in this remedy consists rather in the recalling of the past.

Pulsatilla we of course recognize as characterized by the tearfully yielding mood ; but it differs decidedly from the sadness of nat. mur. in this, that by attempts at consolation you may talk the pulsatilla female into a milder, pleasanter mood ; but try this with the nat. mur. patient and you aggravate the condition.

Sepia develops a state of weeping, anxiety, peevish ill-humor, etc., and the patient may be made "worse from consolation," just as under nat. mur. But, as shown by Farrington, "In natrum mur. the symptoms point more to nervous excitement or weakness alone, hence emotions induce tense headache, animated talking, and drawing up the spine, and unpleasant thoughts cause sadness, paralytic weakness, or irritability without ebullitions. If hypochondriacal, it is a state of melancholy from mental depression, caused by inert bowels ; while in sepia the same state depends also upon portal stasis, and therefore is more persistent and associated with more irritable temper. Natrum mur. may be called for when the mental state depends upon uterine disease or menstrual irregularity, but this will only be a prolapsus, never the uterine engorgement of sepia. The indifference of natrum mur. is born of hopelessness and mental languor ; while that of

sepsia includes an undisguised aversion to those nearest and naturally dearest."

The stannum patient is also low-spirited, nervous, and irritable, but she does not become angry at attempts to console her as under natrum.

With regard to the uterine symptoms of nat. mur., there is pressing toward the genital organs *every morning*, so that she has to sit down to prevent prolapsus. This symptom proceeds from relaxation of the pelvic tissues and is accompanied by some spinal irritation, which manifests itself in "aching in the lumbar region, relieved by lying on the back." Right here is suggested a comparison with kali carb., which has pulsating, drawing, aching in the spine, relieved by lying down, but the distinctly morning aggravation and the melancholia of nat. mur. are sufficiently expressive of the difference between the two.

One more symptom is all we shall consider, that is, "sensitivity to coition." Among the number of drugs that have this symptom nat. mur., stands out prominently as a remedy for *painful coitus from dryness of the vagina*.

—In the metrorrhagia due to uterine fungosities of benign nature there is little or no pain.

—The great majority of women attacked by puerperal peritonitis are of tubercular diathesis.

—In vaginal irritation in little girls, produced by the migration of intestinal worms over the perineum into the vaginal canal, caladium seguinum is the best remedy.

—The old-school have found in nux vomica (one drop of the tincture every half-hour), a new remedy for obstinate cases of menorrhagia and metrorrhagia.

—Dr. Buffett in *La Normandie Medicale* arrives at the following conclusions in a work on the pleuritis complicating ovarian cysts:

First. Pleuritis is a frequent complication of ovarian cysts.

Second. This pleurisy is of an insidious evolution, and this fact ought to enter into consideration in adopting measures for prevention.

Third. It is an indication for early surgical intervention.

Fourth. This intervention should be directed to the ovarian cyst and not to the pleurisy, which is only dependent on the presence of the cyst and disappears with it.

Fifth. All medication addressed to the pleuritis alone fails to give relief.

—Dr. Herman disputes the universally accepted belief that the local use of glycerine causes a flow of fluid from the vagina. The observations were made with cotton-wool plugs soaked in glycerine, and pessaries made of gelatine and glycerine. The amount of glycerine inserted into the vagina was weighed; the discharge from the vagina was weighed, and the amount of vaginal discharge from the same patient when glycerine was not used was also ascertained by weight. He concludes, that when the secretions poured into the vagina were not abundant, the local use of glycerine did not increase them.

—With regard to the use of glycerine, it is a fact that some patients are much more sensitive to its use than others. Now and then we meet a woman who cannot use cosmetics that contain glycerine on account of its poisonous action on the skin of the face and hands. In such a patient as this, who told us that glycerine causes her face to swell and be almost unrepresentable, we once had occasion to use a tampon soaked in glycerole preparation. The result was that next day we had to listen to bitter complainings of a watery leucorrhœa that "soaked all the under-clothing." A tampon prepared with fluid cosmoline and hamamelis was substituted for the glycerole preparation, with the result that we heard no more complaint on the part of the patient.

—The *angular* character of physiognomy is very remarkable among cancerous subjects, even in *latent* disease.

—The characteristic indication in the menstrual condition of erigeron is a sudden gush of blood upon rising.

—Prof. Laramée (*L' Union Médicale*) counts moral causes, especially disappointed love, as powerful factors in the chlorosis of young girls.

—The so-called prophylaxis of puerperal fever may be summed

up in two words—*absolute cleanliness*. This may be just as surely produced by *aseptic* rules without drugs as by the use of the *antiseptic* agents.

—In the purulent vulvitis and vaginitis of young girls it is necessary never to forget the danger of contagion, that the disease may be transmitted from one child to another by the use in common of sponges, linen, etc.

—Natrium hypochlorosum as a gynæcological remedy combines the symptoms of many other drugs. It is characterized by debility in persons of lax fiber and mental and physical slowness. This debility, when attending sexual disorders in women, is accompanied by emaciation and tendency to neurasthenic symptoms. In connection with uterine disease the following symptoms are indications for its employment. Menstrual blood black and clotted (crocus); bearing down in the uterus, which is congested, enlarged, and sensitive; constant oozing of blood, worse from any exertion. (Several drugs have this last; crocus, sabina, and secale, prominently.) Womb feels as if it opened and shut. (Feels as if os uteri were wide open, lachesis.) Sensation as if the uterus was pushed up when she sits down. (Ferrum iod., with bearing down in the pelvis.) Swelling of the left ovary at the menstrual period. (Lach., swelling of the left ovary, with pain, which increases more and more until relieved by the appearance of the menses.) A close comparison with these various drugs shows that natrium hypochlorosum needs very careful differentiation in prolapsus uteri.

TRANSLATIONS FROM FOREIGN JOURNALS.

The Editor is assisted in this department by Dr. S. LILIENTHAL, San Francisco; Dr. H. H. CRIPPEN, San Diego; Drs. PICK and PRITCHARD, Boston.

PARALYSIS NEONATORUM. By A. Boultano, Paris.—Most palsies of new-born infants are of obstetrical origin, either spontaneous or from artificial processes during labor, and such accidents may happen to the most skillful or careful obstetrician; they may emanate from peripheral nerves or from a central lesion; the former is the most frequent and mostly facial. Peripheral facial pa-

ralysis happens mostly from application of the forceps, but may happen spontaneously by compression of the nerve at the angular sacrovertebralis (narrow pelvis), at the ischion or os pubis, perhaps also from pelvic tumors. In some cases it is only partial, limited to the temporal or cervical branch of the facialis, or it may only cause ptosis. On the upper extremities we also meet spontaneous and artificial palsies; the former from enlarged volumen of the shoulders (enlargement of the bisacromial diameter) by compression of the axillary nerve or pressure by pulling of the roots of the plexus brachialis—fascicular or radicular paralysis. Artificial palsies (1) from the position of the head, one branch of the forceps compressing the lateral part of the lower cervical region, or when during retarded expression of the shoulders they are hooked by the hook or the finger, or exceptionally by compression from the umbilical cord. (2) In breech presentation, by pulling at the head, and thus pressing on the shoulder, or by conducting the arms, which were elevated over the head, downwards. (3) In shoulder presentations, by pulling on the presenting arm. Here we have a brachial paralysis of radicular (never of fascicular) type, or hardly ever a total one. Obstetrical paralysis of central origin may appear unilateral with integrity of the musc. orbicul. palp. Central origin of brachial paralysis is not yet demonstrated, but in the lower extremities they were observed from injuries of the spinal cord: tearing, compression by fracture of vertebræ or hæmorrhage in the spinal canal or hematomyelia. Obstetrical hemiplegia is very rare, caused by cerebral hæmorrhage, probably from compression of the umbilical cord. Electrical treatment ought to be early begun.—*Allg. Med. Centr. Zeit.*, 31, '89.

SUDDEN DEATH IN CHILD-BED.*—The most frequent among the causes of sudden puerperal death are; (a) Pulmonary embolism; (b) Entrance of air into the veins; (c) Syncope; (d) Shock; (e) Hemorrhages; (f) diverse maladies. Let us study these causes separately.

(a.) *Pulmonary embolism.*—Death is due to the penetration into the right side of the heart and the arrest in the trunk of the pulmonary artery or its branches of a migratory clot proceeding from

* Dr. Lepage, in *Concours Medical*.

a peripheral vein. In order that there may be a pulmonary embolism, it is necessary then : first, that there be coagulation of blood in a vein; second, that the clot be detached and be carried by the blood-current to the right heart. The accidents differ according as the clot is more or less voluminous; commonly these accidents are marked by gravity and by the suddenness of their appearance in a state of health relatively good. When sudden death appears it concerns usually a woman who is lifted for the first time after her accouchement, or who is sitting up in bed to change her linen, or to take her repast; suddenly she cries out, groans perhaps, sometimes with difficulty articulates, "I suffocate, I die," the head and trunk fall backward, and the woman has ceased to live. Sometimes the death is less sudden, but not the less terrifying. The diagnosis is easy for the following reasons: suddenness of the accident, cause of its production (movement of sitting up or being lifted), previous phlegmasia, dyspnœa, immediate suffocation, feebleness of the pulse, coldness of the extremities. Treatment avails nothing to stop the accident, but it is necessary to use prevention in the way of relieving such troubles as tend to the production of embolism; or failing in the treatment of such troubles as phlegmasia, to advise a lengthened position of repose.

(b.) *Entrance of Air into the Veins.*—The possibility of the introduction of air into the veins by way of the uterine sinuses, and the danger of death from this cause, is now admitted. The intensity of the symptoms depends on the quantity of air which has been introduced into the pulmonary circulation. These symptoms resemble somewhat those of pulmonary embolism; the same suddenness of the accident, the same dyspnœa, the same suffocation, the same need of air, the same anxiety. The differences are: First, the time of appearance of the accident, which follows during or soon after accouchement in the case of entrance of air into the veins; second, the existence of convulsions, which are wanting in pulmonary embolism; third, on a peculiar bruit heard in the præcordial region.

When death is not instantaneous, it is necessary to act as if the air embolism was not a mortal accident and practice artificial respiration. The prophylaxis of this grave accident is very im-

portant ; to keep the woman in absolute repose after child-birth, to protect her from movements of rising from the bed, to make her lie on the back, to do nothing that will cause too rapid expulsion of the placenta. Further, in making a vaginal or intra-uterine injection guard against injecting air at the same time with the liquid.

(c.) *Syncope*.—The cases described under this etiological title are often only those where the true cause of death is ignored : the autopsy is negative ; one does not find sufficient cause to explain the death of the puerperal woman, and the death is ranged, as a makeshift, under syncope.

This accident can follow very abundant or repeated hæmorrhages in consequence of too rapid evacuation of the uterine contents (hydrops amnii, multiple pregnancy), or from a strong moral emotion.

(d.) *Shock*.—Rapid death from shock may follow during labor or shortly after ; the symptomatology is more or less analogous to that of shock from major operations or from great traumatism. Shock attacks especially women exhausted by a prolonged labor or by acute and prolonged pain. Rupture of the uterus, or total uterine inversion, can also produce the phenomenon of shock.

(e.) *Hæmorrhage*.—Outside of the grave hæmorrhages of pregnancy, as those caused by a vicious insertion of the placenta or by rupture of a genital varix, which can occasion sudden death, there are three varieties of hæmorrhages which, after labor, can produce this accident. These are : First. The hæmorrhage of uterine inertia. Second. Latent or internal hæmorrhage, occurring into the cavity of a relaxed uterus or into the peritoneum through a solution of the continuity of the uterine wall. Third. Silent hæmorrhage, in which the blood accumulates in the vagina and only flows outside, little by little.

(f.) *Diverse diseases*.—In the order of their frequency the cardiac affections which can produce death during the puerperal state are : Mitral insufficiency, aortic insufficiency, pericarditis, rupture of the heart. Death does not always follow by syncope, but also may occur as a consequence of pulmonary complications, such as double pulmonary congestion, pulmonary œdema, double plural effusion. By the side of the cardiac and pulmon-

ary affections it is necessary to cite rupture of thoracic aneurism, rupture of the aorta, cerebral and meningeal hæmorrhage, as causes of this accident.

ON CARCINOMA MAMMÆ.—The well-known fact that cancer of the breast is the more malignant the younger the patient is, may be taken as an indication, according to Schinzinger, to castrate such women after the amputation of the mammæ, in order to produce more rapidly the menopause, and thus prevent relapses in these women artificially made old.

Heidenhain, of Berlin, examined eighteen carcinomatous mammæ, amputated by Kuester, in order to find out whether and where in the wound remnants of the gland or of the neoplasma remained, which cause the relapse. In twelve cases he clearly demonstrated these remnants, and most of them are dead, while in the other six no relapse has so far taken place, because the operation removed radically every morbid particle. Relapses will happen if only microscopically visible particles of the gland or of the neoplasma remain on the surface of the musculus pectoralis major. This surface is covered by the fascia pectoralis, which is very thin and its limits undefined, especially in obese women, so that it may be hardly possible to dissect it from the muscle, and remnants of connective tissue are very apt to be left behind when one neglects to remove also part of the muscle. In lean women the mamma *in toto* is firmly attached to the muscle, but in fat women one mostly meets between the gland and the muscle glandular lobules firmly attached to the fascia, so that in amputation above the muscle particles of the gland are easily overlooked.

Every mamma containing a carcinomatous focus must be considered totally affected, for in all microscopical examinations it could be demonstrated that all through the gland the epithelial cells of the acini proliferate, while simultaneously there is also a periacsuous connective tissue proliferation, which, remaining in the wound, causes after a while the relapse. In the retromammary fat, usually close to the blood vessels, one meets lymphatics running to the underlying fascia, and these lymphatics are filled

more or less with carcinomatous metastases. On the preformed road the epithelial proliferation penetrates thick layers of fat down to the muscle, so that usually even freely movable carcinomata reach microscopically the surface of the muscle. The pectoralis major is only then really diseased, when a metastatic cancerous nodule enters it through the fascia or where the chief tumor attacks it by progressive proliferation. Probably the cancer spreads itself also in the muscle through the lymphatics, as by its contractions the epithelial cells are carried onward with the lymph-current.

Heidenhain insists therefore that in freely movable carcinoma mammæ not only the whole breast must be removed, but also the connecting layer of the total surface of the pectoralis major, and where the carcinoma is already found adherent to the muscle, a typical total extirpation of the pectoralis major is necessary, which must be done so thoroughly that not a single fiber of the muscle must be left behind.—*Münch. Med. Wochenschr.*, May, '89.

At the same meeting Landerer, of Leipzig, remarked, that in amputating mammæ, as well as in all large or small wounds after an operation, he follows the principle that no fluid whatever must ever touch a freshly made wound, and cannot too highly recommend this dry treatment to surgeons and especially to physicians practicing in the country. Infection by air and contact may be prevented by the well-known antiseptic measures, the wound cleansed by sublimate-gauze and tamponaded. There will be far less bleeding, and the wound heals kindly without much discharge.

(Homœopathic physicians in Germany have recommended this dry treatment of wounds long ago and probably Landerer learned it from them; let us hope that this good advice, coming now by authority, may find its way into all the corners of the old or the new country, as it is really a blessing to the country physician. A splendid article on this subject may be found in the *California Homœopath* of 1888.

BOOK REVIEWS.

ELECTRO-THERAPEUTICS. By WILLIAM HARVEY KING, M.D.,
Published by A. L. CHATTERTON & Co., New York, 1889.
Cloth, \$2.

It has been said that Apostoli, with his wonderful lamp-electricity, in the medical literature of to-day is the rival of Aladdin of Arabian Nights renown ; but, in the face of such sarcastic obliquity of expression, when we sift from this subject the honest error and the exaggeration to which the human mind is so unconsciously prone ; when we separate conclusions, based upon wide experience and careful investigation, from those hasty deductions founded upon vague hypotheses, there still remains to the credit of electro-therapeutics so many valuable facts that we feel impelled to further research. To this end, then, we welcome the multiplicity of works upon this special subject that have lately appeared, and especially do we extend to the latest comer, the "Electro-therapeutics" of Dr. King, our thanks for the elucidation of several vexatious problems.

Following in the footsteps of Erb and Apostoli, the author has conducted some original researches and placed within his book many new facts.

The chapters on "Electro-physics," "Electro-physiology," "Changes in Nutrition" and "Electro-diagnosis" are without equal in any book so far published, and ought to be thoroughly mastered by every physician before undertaking the department of electro-therapeutics. The description of the construction of the milliampère meter is an especial feature to us, as we have had the pleasure of using one for some time past. Since we first began to use this instrument we have become more and more convinced that the medical man who attempts to treat patients without the instrument labors under disadvantages (that may even become dangerous), and can never arrive at the same accuracy of results which can be obtained when one is able at a glance to estimate the quantity and intensity of the galvanic current and at the same time the approximate resistances of the patient's tissues.

The chapter on "General Therapeutics" is also excellent, as a prelude to special applications, but under "Central Galvanization," we regret to note the author backsliding into the old slipshod ways of designating the current by the number of cells. Before we can make any further progress we must learn in all cases where the galvanic current is used to designate the current by milliampères. Not only this, but we should adopt some standard of primary, secondary, and tertiary coils where faradization is in question.

When we approach the chapter on "Special Therapeutics" we feel that the general practitioner can find no better guide, and this from the fact that *definite* current strengths are advised in nearly all cases. But the specialist will find many vague statements. Whether, or no "*asthenopia*" will be benefited by the treatment the author advises will depend upon the cause.

In gynæcology there are many new hints for the use of electricity, but this agent, though valuable in its place, may be in many cases simply a waste of time. There is yet a wide field of investigation to be covered in this direction, electricity in gynæcology, and though the author deserves credit for much originality, as well as for a careful analysis of the works of others in this branch, we still think that greater advancement will be made in the future; that a better knowledge of the indications for the homœopathic remedy, and a more thorough understanding of etiology, of pathology, and of operative methods will serve to draw *narrower* but *more definite* limits as to the use of this therapeutic agent in our specialty.

To the general practitioner, then, we say, read Dr. King's work; make a careful diagnosis, and if you find electricity necessary, his advice will help you over many a stumbling-block; but to our gynæcological brethren we wish to say, study the authors work with the intention of making original researches.

ELECTRICITY IN THE DISEASES OF WOMEN WITH SPECIAL REFERENCE TO THE APPLICATION OF STRONG CURRENTS. By G. BETTON MASSEY, M.D., Philadelphia; F. A. DAVIS.

In this little book the author does not deal properly with electrophysics. He advises connecting the whole battery up for series and using a rheostat (which he terms a current-controller) to regulate the strength of current used. He also recommends the use of the incandescent electric light current, which he controls in the same manner. The author does not believe that the size and length of the wire of which the faradic coil is composed has anything to do with its special action. He theorizes a little in a foot-note to prove his assertion, but the profession is not interested in the theory; it wishes to know what the practical results are, and the reviewer is very sure that if the opinion of those physicians who have had the largest experience with the different faradic coils could be obtained, they would almost unanimously and emphatically recommend the coils made of different-sized wires for different purposes. The practical part of the book is simply a review of Apostoli's writings, which have already appeared in English in medical journals, with a few cases added from the author's experience; and, as Apostoli's writings have been so thor-

oughly discussed, it is not necessary to dwell upon their merits here. The literary work of the book is good. It gives the necessary details of the various steps of the operative methods, and, at the same time, he has not given too many of those details, thus making it tiresome to the reader. The book is gotten up in good style and is quite necessary to the completion of the gynæcologist's or electro-therapeutist's library. W. H. K.

TRAVAUX D'OBSTÉTRIQUE du Docteur A. AUVARD. Tome deuxième. Lecrosnier et Babé, Éditeurs, Paris, 1889. [Obstetrical Works of Dr. A. AUVARD.]

The second volume of Auvard's work comprises his memoirs not previously published, and has thereby a greater value than the first volume, which, we have seen in a previous review, contained only reprints. In this work the author has confined himself to a few subjects: "The Relation between Adipose and the Puerperal State," "Mechanism of Delivery of the Shoulder (Head Presentations)," "Intra-uterine Tamponing," and "Contributions to the Study of the Ovular Annexes, and to the Study of Delivery of Vulvular Wounds after Labor, and of the Height of the Uterus during the Post-partum"; these are comprised within the 560 pages.

Dr. Auvard is one of the most analytical students of the age (a man of whom we think Dr. George B. Peck, our puerperal statistician, would most decidedly approve); he presents long columns of carefully taken puerperal histories, from which he makes his deductions. Of course the statistical character of the work makes the author somewhat tedious, but, on the other hand, this very feature gives weight to the opinions which are expressed. We do not find ourselves confronted by vague hypothetical statements, but by *facts*.

It is impossible to take up a discussion of all the subjects of this volume, though they are all worthy of notice. That which will most interest all obstetricians is probably "The Mechanism of the Delivery of the Shoulder (in Head Presentations)."

M. Tarnier has written upon this subject, "One grasps the head between the two hands, separating the fingers to take a point of support at the base, and one makes some downward tractions in order to engage the shoulders at the inferior strait. When the anterior shoulder appears under the symphysis pubis, one gently raises the child to release, in turn, the posterior shoulder." To this statement Dr. Auvard opposes a long list of cases which he cites to show, "that the primitive disengagement of the posterior shoulder constitutes the normal mechanism of labor, and that on the contrary the primitive disengagement of the an-

terior shoulder should be considered an anomaly." The question arises, Is it the disengagement of the posterior shoulder first, or that of the anterior shoulder first, which produces the least distention of the vulvular orifice? To this the author answers: "If one wishes to successively disengage the shoulders, and thus to diminish the vulvular distention requisite to the passage of the foetus, it is necessary to commence with the posterior shoulder."

The book has many such practical conclusions intended to further obstetrical knowledge, and, as we have said of the first volume, Dr. Auvard's works form a necessary supplement to the stereotyped treatises on obstetrics.

GYNECOSMOS.

—Mlle. Guiseppina Cattani, privat-docent in general pathology to the Medical Faculty of Bologna, has just delivered her first lecture.

The young doctress proved herself possessed of considerable talent in speaking, and delivered an interesting discussion on "Bacteriology in General and its Importance in Modern Pathology." We believe that Mlle. Cattani is the only female in Europe that holds an official position in a Faculty of Medicine, but there is at the University of Upsal a woman who occupies the chair of Mathematics.

—Female physicians are allowed to practice in Turkestan, but there is so little demand for their services that it is said they pay patients to employ them.

—Mlle. Blanche Edwards and Mlle. Victoria Benoit, both graduates of the French School of Medicine, presented a petition to the last session of the Municipal Council of Paris asking that they be appointed to take charge of a medical service in one of the schools. The petition was received with favor and forwarded to the Administration with a recommendation for the appointment of the two young ladies. The advancement made by medical women in Russia and Italy is stimulating an aggressive movement in France, and we look to the establishment of woman as "internes" to the Paris hospitals as a possible event.

THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

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VOL. XI.

MANAGEMENT OF THE THIRD STAGE OF LABOR.

BY WM. C. RICHARDSON, M.D., ST. LOUIS, MO.

In a recent issue of the *Edinburgh Medical Journal*, D. Berry Hart, M.D., discusses the theory of the cause of separation of the placenta during the third stage of labor, and concludes that the Credé method of expression, as applicable to all cases of labor, is, in his experience, most unsatisfactory.

It is well, no doubt, to constantly bear in mind the important fact that labor, including the third stage, is a natural process.

At the termination of the second stage of labor to immediately assail the uterus with active and violent kneading or compression is as irrational as it is to give an ergotine injection, which is strongly recommended by Dr. Berry.

After the termination of the second stage the old, well-established rule as found in the text-books, to wait fifteen or twenty minutes for the efforts of nature to expel the placenta, should be invariably observed. During this time no manipulations—not even the application of the binder as recommended in the older-text books,—should be un-

dertaken unless hæmorrhage should ensue, in which case active measures must at once be resorted to.

The old opprobrium of *meddlesome midwifery*, as applicable to the present day, consists chiefly in the undue haste in which resort is had to the forceps, ergot, and efforts to accelerate the delivery of the placenta. The great advantages of the Credé method of expression—and the fact that it is so much more satisfactory and expeditious than the old manner of traction—undoubtedly cause it to be practiced too frequently merely to hasten the time when the practitioner can take leave of his patient.

If, at the expiration of twenty minutes, the placenta has not been expelled and there are no evidences of active contraction, then compression of the uterus should be made, not, as is often directed, by pressure on the uterus, but by grasping it in the hand like a ball, through the relaxed walls of the abdomen, and by forcible, yet gentle, squeezing in the direction of the axis of the superior strait. Generally the hand will be made aware, by the decrease in size of the grasped uterus, of the moment when the placenta makes its exit from the uterine cavity.

If, as Dr. Hart claims, bad results have followed the practice of the Credé method, they must be charged to the undue haste in which resort was had to compression. To unduly hasten or force uterine contraction in the third stage is quite as unnecessary and harmful as in the second. Because over-hasty practitioners have had bad or unsatisfactory results from inopportune practice of the Credé method, does not justify or warrant a return to the old method of delivery of the placenta.

Without entering into a discussion of the theory of the manner in which the placenta is separated from the uterine surface, it is safe to assert that traction on the cord and consequent *tearing* loose the placenta from its attachment to the uterus is a violent and unnatural method of effecting a detachment.

There may be instances in which it has happened that the placenta, after separation and expulsion from the uterus, has, through lack of sufficient contractility of the vagina, been retained within that organ. The inexperienced or over-timid practitioner might, and no doubt has occasionally had, unsatisfactory and unfavorable results from not removing the placenta in such cases by means of the cord. Cases of this kind are, however, rare, and do not furnish any grounds on which to base an argument against the method of expulsion by compression.

In conclusion, it is safe to say that the safest, most expeditious, and satisfactory way to terminate the third stage of labor, where nature fails in her efforts after the lapse of due time, say twenty minutes, is by compression, or what is generally known as the Credé method.

THE GENU-PECTORAL POSITION IN TRANSVERSE AND OBLIQUE PRESENTATIONS.

BY T. F. H. SPRENG, M.D., SIOUX CITY, IOWA.

Of the very many different positions that women assume naturally, and of those advised by the attending physician, I desire to speak especially of the advantages to be gained by assuming the knee-chest position in trunk and oblique presentations.

Fortunately for the mother, the child, and the doctor, these positions are not common. This very fact leads me to the selection of this subject for a paper.

To make the knee-chest position more effective, prepare the bed by folding blankets, so that the pile will raise the knees from fifteen to twenty inches from the bed; instruct the patient to kneel upon them, and lay her breast upon the bed. Your patient is now in position to be aided by the force of gravity,—the foetus is carried out of the

superior strait, and thus relieves any impaction which may exist. All this causes partial cessation of the pains, and in consequence prevents the patient from bearing down, which bearing down you will invariably find a most serious obstacle to successful manipulation. The hand and forearm, thoroughly lubricated, can now, with ease, be introduced into the uterus. If the position of the *fœtus* is such that cephalic version can be performed, then that will be the course to pursue, and the labor is allowed to terminate itself in the ordinary manner. If cephalic version is impossible, then bring down the feet, and treat as a case of breech presentation.

This mode of management may be employed in any transverse or oblique presentation, especially in those cases where the head is found in either the right or left iliac fossa. When you have been waiting, with a hope that spontaneous rotation might take place, this position assumed may at once bring about this rotation, and thus change it from an oblique to a vertex presentation.

In this position even a face presentation, when it is necessary to use instruments, may, by external manipulation alone, be converted into a vertex presentation, where the forceps can be applied to the sides of the *fœtal* head, and thus avoid mutilation of the child, as is sometimes the case where forceps are used in face presentations.

Again, the genu-pectoral position is the most favorable for the ready return of a prolapsed funis.

Two examples, selected from my case-book, will serve to illustrate the practicability of this position.

CASE I.—Mrs. L., primipara, aged thirty years, was taken in labor July 7, 1886. I was summoned the following morning; active labor had been in progress for fourteen hours. On examination found the os fully dilated and the head of the *fœtus* in the right iliac fossa. Uterine contractions were very irregular, and patient much exhausted. The membrane ruptured six hours before my arrival. The

patient was placed in the knee-chest position, with knees elevated; this brought immediate relief. With the fingers of the right hand pressed hard against the presenting head, and with the left manipulating the abdomen, rotation was easily effected and the vertex brought to the superior strait; a few vigorous pains expelled a ten and a half pound baby girl.

CASE II.—Mrs. M., multipara, aged thirty-eight. In a period of eighteen years passed through several normal confinements; has been in good health during last pregnancy. Labor began on the afternoon of March 25, 1889. Her physician was summoned that evening. At 3 o'clock the following morning I was called in counsel. Pains were very irregular and ineffective. The left hand of the fœtus and the cord were protruding from the vagina, cord pulseless, and the doctor informed me that it had been so for the last four hours. The membranes had ruptured before the attending physician arrived. The arm and funis were both in the vagina, on his first examination, the cord pulsating. Before my arrival he had made many futile efforts to return cord and arm. We put the patient in the knee-chest position, with knees upon a folded comforter. The cord receded of its own accord and the arm was easily returned. The life of the child having been sacrificed, we did not attempt to perform cephalic version, but at once passed the anointed left hand to the fundus, where the feet of the child were firmly grasped, and then gently performed podalic version and completed the delivery as you would a footling presentation. The child weighed eight pounds.

It will be observed that in both these cases the membranes had ruptured and the amniotic fluid had escaped several hours before version was performed; notwithstanding this fact the operation in both was a comparatively easy one.

It is always advisable to perform version with the membranes intact, for the presence of the fluid, in which the

foetus floats, will aid greatly in properly placing the foetus for a normal delivery; this having been accomplished the membranes are ruptured; but see to it that the child retains its new position until several firm contractions have occurred. Carelessness in this might call for a repetition of the work just accomplished.

I firmly believe that the life of the child, in the second case, might have been saved had the knee-chest position been assumed before the cord ceased pulsating.

PUERPERAL RETENTION OF URINE.*

BY SHELDON LEAVITT, M.D., CHICAGO.

This is one of the most frequent complications of the puerperal state, and occasionally proves to be one of the most annoying.

The prudent accoucheur encourages his patient to keep the bladder empty during parturition as long as voluntary micturition can be performed.

This is not all, for it is hardly safe to put the utmost reliance upon the result of voluntary urination, since, even during parturition, there may be vesical atony resulting in partial retention. It is, therefore, wise to make careful palpation and percussion of the hypogastrium to determine whether the bladder gives evidence of distention or of complete evacuation. In case of doubt, the catheter ought to be carefully passed. Having made himself sure of vesical non-distention up to a late moment in parturition, the bladder will receive no farther attention until some hours after delivery. In many instances the woman experiences a desire to micturate within the first few hours; but in many other cases, ten, fifteen, or even twenty, hours may elapse before the patient's attention is drawn by her feelings to

* Read before the American Institute of Homœopathy.

the performance of this act. An effort is then made, which may prove utterly futile, and the patient find herself wholly unable to afford herself the coveted relief.

This condition of urinary retention is liable to occur after an ordinary case of labor, but it is oftener observed after delivery attended with extreme difficulty, and terminated either naturally or artificially. Still it is in only a certain percentage of instrumental deliveries that the complication is met.

The etiological factors are here two in number: the one, extreme atony or partial paralysis, and the other, spasmodic contraction of the sphincter vesicæ. The former is chiefly the result of dystocia, the bladder being constrained and somewhat crippled during pregnancy by extreme uterine distention, and finally overpowered by a tedious parturition. Spasmodic retention is sometimes a hysterical manifestation, but is oftener a result of irritation reflected from a torn vestibule or perinæum. I am personally of the opinion that the greatest proportion of all cases of urinary retention find their immediate cause in vesical atony.

It is a clinical observation that retention which is not soon overcome is extremely liable to become prolonged, and may even annoy the woman until she is able to be about the room. I believe it never far exceeds these bounds.

Treatment.—Every precaution should be taken to avert this annoying complication of puerperality. There is not much to be done, except to observe ordinary care in the general management of the case during parturition and the period immediately succeeding it; but there are some things which we ought most scrupulously to avoid. What has impressed this truth forcibly on my mind is a case which I witnessed some time since, in which, a few hours post-partum, most injudicious treatment was adopted. The woman had passed through an instrumental delivery of considerable difficulty, and at the first visit, made a few hours thereafter,

the excellent practitioner who had charge of the case, assuming that there would be urinary retention, without giving the woman an opportunity to empty the bladder in a natural way, assured her that she would not be able to do so, and passed the catheter. The after history was in keeping with the assurance given, and artificial means for vesical relief were found necessary for a number of days. To be sure this patient might have failed to urinate if given the opportunity, and encouraged by a more favorable prognosis; but I believe that retention is sometimes excited by unnecessary interference. This I regard as an example of meddlesome midwifery. Another important precaution to be observed is, to have the woman make one or repeated attempts to urinate within the first six or eight hours after delivery. This I regard as a maxim of wise policy, inasmuch as distention of the bladder is inimical to spontaneous evacuation. There are many women who find themselves absolutely unable to urinate while in the recumbent posture, who readily succeed when allowed to sit. It is accordingly my practice to direct, that in the absence of decidedly contra-indicating conditions, the patient be permitted to assume the sitting posture if necessary, and I have not had occasion to regret the permission.

There are certain remedies which, under these circumstances, are capable of lending considerable aid.

Belladonna is one of the best of them, and is especially indicated in those cases where there has been small loss of blood, and the pulse discloses considerable arterial tension. Spasmodic retention is more likely to give way under this remedy than is retention due to vesical atony, although in both instances it may prove efficacious.

Camphor is also said to be a good remedy, but I have thus far observed no favorable effects from its use.

Aconite is specially serviceable when the woman has exhibited strong reaction from the strain of labor, attended with a moderately strong and rapid pulse.

Arsenicum is sometimes effective where there is retention unaccompanied with desire to urinate.

Nux Vomica is indicated by frequent or constant desire and ineffectual effort.

The Faradic current has been found serviceable in some of these cases, especially those wherein the retention is attributable to uterine atony.

These are the only remedies which I now recall as having been in any degree serviceable in the affection now under consideration.

There are little expedients, such as the use of hot fomentations and gentle kneading of the hypogastrium, that occasionally contribute to the effect sought; and are worthy of trial; but, despite them and any other remedial agent at our command, we are occasionally driven to conjure the aid of the catheter.

This instrument, however, ought not to become our sole reliance; but remedies should be continued, and the woman encouraged to make frequent, though not strong, efforts at suitable intervals. In case of failure the catheter should be introduced every six or seven hours, and the bladder thoroughly emptied. When we are driven to use of this instrument for any considerable time, it is well, every twenty-four or forty-eight hours, to wash out the bladder with a mild antiseptic solution.

Repeated use of the instrument is liable to set up urethritis, and therefore the operation must be performed with the most extreme delicacy. In the absence of a trained nurse it is better for the attending physician to use the instrument. Still, an intelligent attendant with a little instruction can be made competent to introduce under vision.

It goes without saying that this little operation should not be performed in neglect of antiseptic precaution. Many nurses are grossly heedless, and require repeated injunction, and close surveillance. I am fully persuaded that serious results have many times proceeded from use of an unclean catheter.

THE INTRA-UTERINE SPRAY IN DISEASES OF
THE ENDOMETRIUM.*

BY EDWIN M. HALE, M.D., CHICAGO.

During my experience in treating diseases of the lining membrane of the cervix and fundus of the uterus, I have used many, if not all, the methods recommended for applying remedies to those surfaces. I have found all methods but one open to many and often serious objections. The first and all-important requisite before all but one method is used, is that the cervical canal must be dilated widely—much more than normal. The uterine cavity will not tolerate any fluid or solid substance, unless that substance can have free exit. If confined, it causes not only uterine colic, but metritis, parametritis, pelvic cellulitis, or peritonitis. Now it is not always easy or advisable to dilate the cervical canal to the required size. If we attempt it with tents, like sponge, sea-tangle, or tupelo, or even by the method of rapid dilatation with instruments, there is danger of septic infections, or the above-mentioned inflammations. Tents of slippery elm are the least objectionable, but they do not dilate to any extent. The cervical canal enlarges under their use; it is not a mechanical dilatation, but a physiological. I have used the wire brush, the cotton or linen swab, pencils, suppositories, and injections with all sorts of syringes, but they are all fraught with danger. They irritate the uterus unless the fluid injected has a free outlet by which to escape. Finally, I found in Buttle's syringe an instrument which came the nearest to a desideratum of anything yet invented. The syringe, as I used it first, was made of hard rubber; the barrel held about one dram, and the nozzle was delicate and slender, and near its distal extremity was perforated at its sides, laterally, with several small orifices. When the contents were expelled, it issued in the

* Prepared for the Massachusetts Surgical and Gynecological Society.

form of a fine spray. I used this for several years with great satisfaction, but I found that it could be improved upon. Its defects were: (1.) In pushing the nozzle, the spray could not be regulated in quantity, except by regulating the amount of fluid in the barrel, and this was not always an easy thing to do; (2.) The nozzle could not be bent to suit the curve of the cervical canal except by heat, and it often broke in the attempt. To make the instrument more perfect I had one made with a screw on the piston. On turning the piston I could regulate to a drop the amount of fluid I desired to place in the uterine cavity. By loosening a cap which screwed on the end of the barrel nearest the operator the piston could be worked to throw a spray. I had the nozzle made of silver which can be bent to any desired curve.

With these improvements I have an instrument which is capable of great usefulness and devoid of danger. There are several methods of using this syringe: (1.) When the os and cervical canal is patulous—so that liquids or semi-solids will readily run out, we can inject a dram or less of any medicament. If it is absolutely necessary to use such powerful applications as strong nitric, chromic, or carbolic acids, the rubber nozzle is best, as metal is injured by them. I use both, but rarely use the strong acids.

If the canal is abnormally small, I use one of the elegant slippery-elm tents now manufactured. If these are allowed to soak in warm water a few minutes, their surface is covered with a mucilaginous exudation, and the small one can be bent to any desirable curve.

For safety I impregnate the water in which they are placed with mercuric chloride, 1 to 3000, or any other antiseptic substance. After remaining in the canal from two to six hours, it will be found that dilatation has taken place, although the tent has swollen but little. Then we can use the spray in any quantity, one dram or less—or apply the medicament *guttatim*.

(3.) If the cervical canal is permeable by a sound one-eighth of an inch in diameter (its normal) the spray can be used in small quantities, or by drops, and as the nozzle is only one-sixteenth of an inch in diameter, the fluid can escape along the sides.

But it is better to remove the nozzle in such cases as soon as any quantity above five drops is applied, for fear the inner cervical os may contract and retain it. I have never had uterine colic occur after an application under the above rules, but three times, and in those it lasted less than an hour.

I will now mention several medicaments which I have found most useful, and their indications.

Hydrastia Muriatica.—This is the white alkaloid of *hydrastis canadensis*. I prefer the 1 or 2 per cent. solution, rarely stronger. It is the chief remedy in uterine catarrh, when the discharge is tenacious, stringy, white or yellow. If mainly cervical, the canal should be thoroughly cleansed before its use.

Kali bichromatum is indicated for the same condition, when the discharge is of a more serious character, and mixed with pus and blood; and when we fear the presence of fungous condition of the endometrium ($\frac{1}{100}$ to $\frac{1}{1000}$.)

Chromic acid.—In graver cases, when the cervical canal is the seat of fungous granulation, and also the interior of the uterine cavity. In such cases, it is often necessary to use the 50 per cent. solution, although the 10 or 20 per cent. can be first used, but carefully, in all cases, allowing only a few drops to escape by spray or *guttatim*.

Carbolic acid is indicated when the discharge is thin, milky, serous, irritating, and offensive. I have had best success with the 50 per cent. spray, or the 95 per cent. *guttatim*.

Nitrate of Sanguinaria, is an admirable remedy when we must combat erosions, irritable and bleeding granulations, or polypoid growths. It is a powerful caustic and efficacious

from the 1 to 3 per cent. solutions, and even much weaker.

Thuja occidentalis almost equals any of the above, and can be used successfully in any of the above-named conditions, especially when the disease is due to recent or old gonorrhœal infection—a common cause of the most intractable diseases of the endometrium. It is singularly non-irritating, and can be used even in the fluid extract; if diluted, it should be with glycerine.

Phenol-Iodine (equal parts of 50 per cent. carbolic acid and tincture iodine), is of great benefit in certain cases where there is flaccidity and hypertrophy of the uterus, in strumous subjects. In chronic oozing hæmorrhages, or even profuse hæmorrhages from cystic degenerations, etc., a spray of twenty or thirty drops of this fluid will often arrest it promptly and permanently. If this fails, resort to 50 per cent. chromic acid; fl. ext. white pine bark is the best and most potent of all astringents, while it modifies the diseases of mucous surfaces. I often mix, or alternate it with the dilute oil of eucalyptus. Many other medicaments could be mentioned and praised, but the above are my favorites. There is another method of using this syringe which I sometimes adopt, and find it very useful. It was first proposed and practiced by Dr. Paul F. Mundé. I quote the description of his method from his "Minor Gynæcological Surgery":

"Several years ago, having by experience become fully alive to the objections against the ordinary uterine applications, I chanced to meet with Buttle's uterine syringe, and it occurred to me that a very good way to avoid the expression and albumination of the fluid in the cervical canal would be to first fill the syringe with the application fluid, then wrap absorbent cotton about the uterine portion (precisely as described for the applicator), introduce it and gently express the fluid. The dry cotton having thus been introduced into the uterine cavity, the slow expression of the fluid would gradually saturate the cotton, and the

agent thus in its undiluted condition come in contact with the endometrium. I at once put this idea into execution, and found that it answered perfectly—the very slender nozzle of the syringe (which is of hard rubber and holds about one-half a drachm of fluid) when wrapped by a thin film of cotton, presented no obstacle to its introduction through almost any normal cervical canal; the thin film of cotton allowed the fluid to ooze through it gradually (as can be seen on trying the experiment outside of the body), and the shock of the rapid injection of fluid was thus avoided. Nothing but the usual slight sensation of warmth in the hypogastric region, occasionally moderate pain, was experienced. As soon as the cotton was saturated, the fluid escaped from the external os: and this was a sign to cease the injection. I made the application usually through a Sim's speculum, but frequently through a large cylindrical or bivalve, and found no difficulty in passing the slender cotton-wrapped syringe tip to the fundus uteri.

“Only in three or four instances did I witness more than the above-mentioned slight hypogastric pain. I have applied through this syringe only the tinctures of iodine, (simple and compound), the pure and impure carbolic acid, the nitrate of silver (3 j to $\frac{3}{4}$ j), and pure nitric acid. Of these the nitric acid, the impure carbolic, and the silver nitrate solution alone produced a decided constitutional shock, which in two instances required the hypodermic use of morphine, alcoholic stimulants, and a rest of several hours, in the others only rest. The iodine in no case produced an unpleasant reaction. In order, however, to avoid even this rare shock, I adopted the plan of propelling the piston of the syringe merely by turning it as one does a screw, and withdrawing it as soon as I noticed fluid escaping from the external os.

“In this manner any sudden forcing of the fluid through the cotton into the uterine cavity was avoided and an excess at once relieved.

"I have employed this method many hundreds of times, and am convinced that it is the most efficient, convenient, and safe method of making intra-uterine applications. Even the application of nitric acid, which was only once followed by a shock, was performed through an undiluted uterine canal.

"Had previous dilatation been practiced, I am confident no reaction would have occurred, and subsequent experience confirms this view."

"THE DIAGNOSIS AND TREATMENT OF EXTRA-UTERINE PREGNANCY" CONSIDERED.

Ab'do intra muros.

Lusus naturæ.

BY W. IRVING THAYER, M.D., BROOKLYN, N. Y.

Before any abnormal condition can be wisely and intelligently considered and treated, with a view of restoration to a physiological agreement, or return of health, nothing can be of more importance than to make out a sure and correct diagnosis: this is especially true if there is a prospect of surgical interference becoming necessary.

It will not surprise the reader to be informed that the diagnosis of an uninflamed and unruptured ectopic pregnancy during the early weeks of such a condition, is a thing rather difficult to do with positive certainty; yet can be, and is frequently done.

But if the sac has ruptured, then the condition has changed materially, by variation, and intensity of some of the symptoms.

THE CAUSE extra-uterine pregnancy is anything that will OF operate to change the normal relation of the uterus with the Fallopian tract, or its fimbriated extremity, changes in the tube itself, salpingitis—so as to offer an obstruction to the passage of the ovule to the womb; these conditions may be brought about by various traumatic

injuries, pelvic cellulitis, diffusing endometritis, malposition of the uterus, tumors, peri-uterine cysts, and other abnormal conditions. Extra-uterine pregnancy

CAN OCCUR sterile, as well as in the multipara. Indeed, IN THE some gynæcologists claim that the sterile, or those who have not been pregnant for a considerable number of years, are more predisposed to ectopic pregnancy than some others. However, this fact should be borne in mind, in search of facts to pass judgment upon, that, in the large proportion of cases, there has been a long period of sterility preceding extra-uterine pregnancy. Previous to any

PELVIC HÆMA- what are the symptoms—if any—that
TOCELE will assist the physician in making out
a diagnosis as to whether extra-uterine pregnancy exists, or, if that condition is not suspected, are there any symptoms that will lead a cautious and well-informed examiner to such a conclusion?

In an examination of several hundred reported cases, the writer has been unable to find even one case in which there was not first,

A CESSATION for one, at least, and usually two
OF MENSTRUATION or more periods. But amenorrhœa is more or less frequent, and arises from many different causes. Still, taken with the history of the case, such as a previous uninterrupted menstrual flow, and other concomitant symptoms, it certainly is of great pathognomonic value; it can, with great propriety, be considered *as a valuable characteristic sign*, and one of several others. Three prominent symptoms *must always* be present.

SECOND. NOT majority of patients have, BEFORE
ALWAYS, BUT RUPTURE, qualitative symptoms, such
A VERY LARGE as enlargement of the uterus, nausea,
disorders altogether strange and new,
even to her who has been pregnant before. Sometimes

a sanguinolent watery discharge, abdominal and pelvic pains of moderate intensity in the early weeks, lasting an hour or two, and taken in conjunction with the "wine cast" vaginal hue, are suspiciously characteristic, and should awaken careful and thoughtful investigations. Temperature may be slightly raised. Pulse 80 to 90, and in some cases slightly more.

PELVIC TENDERNESS even, before rupture, especially after somewhat severe cramp-like pains, which may show themselves as early as the sixth week after cessation of the last regular catamenia; yet, rupture seldom occurs before the eighth week, usually about the tenth, to the thirteenth week. Then, when the

WOMB IS inclined laterally, or forward, a patulous os, DISPLACED, softened cervix and uterus enlarged, with a growth that cannot be well accounted for, roundish, movable on one side or behind the womb, and all taken together, are strong characteristic signs of ectopic gestation.

A LINE OF ANTE-RUPTURE extra-gestation symptoms, that are pathognomonic, will be shooting, sickening, and darting pains, associated with a very deep soreness situated in the right or left groin or iliac region and in vicinity of the Fallopian tube, joined with low sacral pains and sciatic neuralgia, with mammary tenderness and possible colostrum, aggravated near the catamenial period and occurring after a regular course of menstruation, yet occasionally exhibiting—during other symptoms—a sero-sanguinolent discharge, with an anxious, nervous fear, found in conjunction with a period of sterility.

AN ANALYZING JUDGMENT should assist the examiner in search of farther objective symptoms, such as an oblique position of the womb, increased size of the uterus, depressed vaginal vault, softened cervix, and *increased uterine canal*. Dark abnormal—reddish-purple—color of vaginal walls, and

by bi-manual examination, by way of vagina and rectum, searching for any abnormal growth or tumor. The uterus will be found higher up than when in a normal position. These sudden, sickening, fainting, and darting pains occur most frequently in the seventh, eighth, and tenth week, and should arouse the gravest suspicion.

THE ATTENDING ought to make a vaginal examination, PHYSICIAN either in the right or left lateral position, and also, if possible, in the genu-pectoral position, when the patient seeks advice when first symptoms appear, such as an unusual *sudden*, severe, sharp, and a more or less continued pain occurs. These pains

ARE CAUSED a fissure or rent of the tube, and possibly BY STRETCH- sac, or ligamentous ectopic environment. ING, It is believed by the writer, that all extra-uterine foetation is first tubal. There is a stretching of the peritoneum and a local peritoneal inflammation, all of which, in whole, or part, may be repeated before actual rupture takes place.

ONE SHOULD misled when a goodly line of the above NOT BE symptoms are markedly patent, by a subsequent monthly flow, or an irregular hæmorrhage,—for the latter is very common—so as to doubt tubal pregnancy, and imagine that possibly he has had to contend against a miscarriage. Such an error as the latter condition could not be made, were all of the symptoms weighed separately, and then taken conjointly, and adjusted in an equal balance.

NORMAL should be excluded in a diagnosis where such PREGNANCY *sudden*, *agonizing*, and *recurring* pains occur, before or after rupture, and the soreness and excessive tenderness is to the right, or left, or posterior to the uterus; for no normal pregnancy nor abortion can produce such an array of unusual symptoms, while all of the

above symptoms actually occurred, not all in one, but most of them in each, and in different clinical cases, and point to in each case extra-uterine foetation, which was proven to have existed, and *not*, intra-uterine pregnancy or other abnormal condition.

FETAL HEART foetal movements, in those cases that
SOUNDS, AND retain about normal size of uterus, and
 that progress with few or no untoward
symptoms as shown above, is proof positive of ectopic pregnancy, though it is exceedingly rare for a patient to advance so far. These *sudden, sharp*, and *agonizing pains* that *always* occur *after* rupture, are much more reliable and characteristic of a ruptured sac, than of an unruptured one.

THERE ARE cases reported that have gone on to term,
A FEW and one to ten and a half months, before
 rupture or any distressing or peculiar symptoms having occurred—though they are very rare—such as the case reported by Dr. Waldo Briggs. Dr. F. C. Vandervoort reports a case where a patient claimed to have gone on to full term, before rupture and discharge of deciduous membrane. Dr. John Pennefather reports a case from October, 1866, to April 3, 1867, or six months before rupture, then case continued to progress to full term of a normal pregnancy. Extra and intra-uterine pregnancy advancing at one and the same time, for the first six months.

THESE CASES wide exception, and should not permit the
ARE THE wise diagnostician to relax his keen, solicitous, suspecting watchfulness, and rob him
of a true diagnosis.

IT IS VERY find any case of any pathological condition,
RARE TO where two different patients have identically
 the same symptoms, though they may have
many very similar signs in common; yet there are shades

of difference, and these same facts hold true in regard to ectopic gestation.

A TYPICAL of extra-uterine foetation that would be CASE pathognomonic, is, where a patient has not menstruated for two or three months, morning sickness, with other reflex symptoms that usually accompany the first months of gestation, attended with frequent attacks of deep-seated pelvic pains, at times severe, and followed by spurts of blood from the vagina. The breasts increase in size, the areola darkened, and the papillæ prominent. At the end of the seventh or eighth week, there begins to be a perceptible enlargement of the right or left Fallopian tube, or region, and when it is not due to any inflammatory process, it is pathognomonic; especially when, by bi-manual touch, per vaginam, or rectum, a small, rounded, movable tumor is detected. If there is excessive tenderness, preventing such an examination, it will be better to make the same by the aid of an anæsthetic, care being used so as not to break the sac, if no rupture has taken place.

SUMMARY, These are characteristic symptoms, 1st—Ces-
before RUP- sation of menstruation, one term, usually two,
TURE. possibly more. 2d. *Sudden* pain, rapidity or
swiftness of coming pain being especially
pathognomonic. 3d. Severe pain, different than in intestinal or uterine cramp; a sharp, prolonged, low pelvic pain, that is *new, unusual*. 4th. A sickening pain. 5th. Alarmed? 6th. Changed position of the womb. 7th. Patulous os. 8th. Softened cervix. 9th. Wine-colored vaginal walls and cervix. 10th. Enlarged uterus. 11th. Depressed vaginal vault. 12th. Discovery of a lateral or posterior, rounded, movable tumor. 13th. A sero-sanguinolent discharge from the vagina, but *after* rupture looks dark, more like coffee-grounds. 14th. A darkened areola around mammary nipple; and 15th, prominent papillæ. It should be understood that not all of these symptoms are present in each

individual case; but many of them *must be*, though they may differ in intensity, or prominence.

NOW, *after* have a similar line of symptoms, which are RUPTURE, WE GREATLY INTENSIFIED, and others so well-marked as to clear from the mind the possible doubts that may have previously existed. *More severe pains*, simulating premature and spurious labor pains, with GREATER TENDERNESS and SORENESS than was first experienced. Now the discharges from the womb look darker, much like coffee-grounds, accompanied with small clots, smelling offensive.

TEMPERATURE SOON up to, and above 100°. Pulse 85, 90, 96, 100 to 130. A lobulated, irregular, hard or doughy mass, likely to fill the right or left lower part of the abdomen. A patulous os. Cervix softened and rather inaccessible. Uterine canal increased in length, oblique, and rather anterior to the tumor. A baggy mass likely to fill the *cul-de-sac*. Vagina purple and *vascular*, and the appearance of a DECIDUOUS MEMBRANE, which the physician ought always to see, because it is a *positive characteristic sign*, provided there has been no history of membranous dysmenorrhœa.

THESE EXCRUCIATING, TERRIBLE ATTACKS of pain are almost invariably SUDDEN, and this *suddenness* becomes of *still greater* pathognomonic value.

SYMPTOMS THAT pointedly indicate internal hæmorrhage would throw great light on the diagnosis, and are markedly characteristic of ectopic gestation; such as fainting and approaching collapse. These *sudden, excruciating* pains are pathognomonic when accompanied with partial syncope. Pains with increasing symptoms of shock,—feet and hands cold; intellect clear. From moderate to extreme pallor. Mammary glands now may be, and are liable to become, flaccid.

THE OCCUR- of severe unaccustomed and otherwise un-
 RENCE accountable pelvic pains, in a woman who
 has missed two catamenias, should seriously
 arrest the attention of the physician,—especially if they
 should recur again with symptoms of fever, hæmorrhage,
 and shock; for such symptoms should excite his suspicion
 of tubal pregnancy, when there is strong evidence of ab-
 dominal hæmorrhage, with intense pain in the iliac region,
 great prostration and partial collapse.

WHEN VOM- occurs, it is frequently almost incessant,
 ITING and more persistent than in abortions, or
 normal gestation, though very rarely occur-
 ring in the latter, that has approached term.

AMONG SEVERAL reported cases examined by the writer,
 HUNDRED none has been found that did not
 sooner or later, after rupture, expel a
 decidua vera. In certain cases the pulse may be rapid, yet
 very feeble, bordering on collapse, indicated by cold sur-
 face, cold clammy sweat, and listlessness.

THE *location* their *suddenness*, *excessive tenderness*, and a
 OF THE PAINS, *lateral located tumor*, with a non-gravid
 uterus, are reliable pathognomonic symp-
 toms, when associated with other evidences indicating
 rupture.

BUT, WHY rupture? The proofs are so clear in a
 WAIT FOR majority of cases, that it is almost inexcusa-
 ble to wait and assume more weighty respon-
 sibilities. Yet we do not hint here of any line of treatment.
 So far, we have been interested to investigate, if, indeed,
 there be any reliable symptoms that would enable an exam-
 iner to ascertain if ectopic gestation existed in a given case.

BECAUSE a similar set of symptoms, yet not identical,
 THERE ARE that can occur in other pathological condi-
 tions, they by no means militate against a keen
 observer being able to detect extra-uterine fœtation before
 rupture. It has been so detected, twelve separate times,

by Dr. Thomas, eleven times by Dr. Rockwell, and confirmed by such eminent authorities as Thomas, Emmet, McBurney, Jauvrin, Sims, Bache, Lee, Herrick, Goelet, and many others. This would seem to be sufficient proof that a diagnosis of extra-uterine pregnancy CAN BE MADE OUT BEFORE RUPTURE!

TREATMENT.

NOW AS REGARDS nothing teaches so well the road to TREATMENT, success, for which the profession devoutly prays, as the narration of facts found in actual practice, and the results that have attended the diagnosis and treatment adopted.

A LIST OF EXTRA-UTERINE PREGNANCIES AND OTHER PATHOLOGICAL CONDITIONS, THAT HAVE BEEN TREATED BY ABDOMINAL SECTION; AND THE RESULTS.

Prof. Wm. Goodell performed in 1887, 53 laparotomies, with 46 recoveries and 7 deaths. Per cent recovered, 87.7; mortality, 13.3.

Dr. T. G. Thomas. Extra-uterine pregnancy. A full-grown child extracted. Placenta removed the ninth day. Recovery. P.C. recovered 100.

Dr. Thomas has performed four other laparotomies, and all recovered. P.C. recovered 100.

Dr. J. B. Deaver. Laparotomy for rupture at sixth week. Patient died. P.C. mortality 100.

Dr. Wm. McCollom. Rupture of extra-uterine pregnancy. There was a delay from Dec. 2 to Jan. 6. Proved fatal. Autopsy showed extra-uterine pregnancy of twelve months standing. P.C. mortality, 100.

Prof. W. G. Wylie reports sixty-one consecutive laparotomies without a death. P.C. recovered, 100. Remarkable record.

Dr. Wm. Cunningham reports a patient of sixty-one years,

who had noticed a tumor for twenty years. Operated. The face, arms, legs, and whole front part of foetus had been absorbed. Patient died. P.C. mortality, 100.

Dr. W. D. Hamilton. Laparotomy. Foetus of seven and a half months extracted. Good recovery. P.C. recovered, 100.

Dr. Skene, Brooklyn. Laparotomy Dec. 20, 1887. Died in fourteen hours. As early as the 19th, was found almost in a collapse. P.C. mortality, 100.

In thirty-five laparotomies, Tait had two deaths, each of the operations were for tubal pregnancy. P.C. mortality, 05.8.

Dr. Chas. E. Taft. Tubal pregnancy. Laparotomy. Full-grown child. Pregnancy dated back a year and a half. Recovered. P.C. recovery, 100.

Dr. Waldo Briggs. Ruptured tubal pregnancy. First saw the patient fourteen months after first signs of pregnancy. Multipara. Foetus weighed fifteen pounds. Died in fifteen hours after laparotomy had been performed. P.C. mortality, 100.

As abdominal section for complete ovariectomies, hysterectomies, removal of ovarian and uterine tumors, are so closely allied to laparotomies for extra-uterine pregnancy, it is not unjust, neither can it tend otherwise than to assist in arriving at a correct conclusion, as to the results attending the opening of the abdominal cavity for various purposes.

Therefore we will add 338 cases of abdominal section, attended by 86 deaths, covering a period of thirty years, and performed by the late Prof. Walter Burnham, M.D. Most of the operations by Dr. Burnham were performed under unfavorable circumstances, at private residences, without the advantages of trained nurses, or of our modern antiseptic treatment. When we consider the removal of tumors weighing 30, 40, and 60 lbs., and where cyst-walls are three-fourths of an inch thick, and the fluids and portions removed weighing 130 pounds, and some of these tumors

of from two to ten years' standing, with all of their resisting adhesions, we plainly see how we can place such operations in our list.

Granting that his cases would average 60 per cent. more risk on account of not having as good antiseptic treatment and trained nurses to help him through, we find, if we are willing to accord him this just estimate, that his death-rate would be reduced from 25.4+ to 15.2+ per cent. Yet, in our table we make only the most *unfavorable* facts patent.

Now, the facts are that two of his cases

Died from diphtheria,	2
Two from catharsis,	2
One from hæmatophilia,	1
One from diarrhoea,	1
<hr/>	
Total,	6

Now to pass a proper judgment on his "works" which do "follow" him to the better land, his mortality, by removing the six cases cited above, will reduce his mortality record to 14.16 per cent. Certainly a marvelous record for such early days, from August, 1851, to August, 1881. Still, it will be noted in our table that we have taken the facts as we have found them, and allowed no mitigating probabilities. P.C. recovered, 74.4; mortality, 25.6.

Dr. N. T. Brewis, Edinburgh, has performed twelve laparotomies for salpingitis, prolapsed ovaries, cystic degeneration of the ovaries, cirrhosis, and myoma of ovaries, resulting in ten cures. P.C. recovered, 83.4. One greatly improved, one no better, and *no deaths*.

Surg. Maj. Arnott, M.D., Edinburgh. Cæsarean section. discharged July 31, 1887, in good order; cured. P.C. recovered, 100.

Rutherford Morrison, M.D., Newcastle. Extra-uterine pregnancy. Abdominal section and removal of fœtus. Recovery. P. C. recovered, 100.

Dr. Geo. C. Jeffery, Brooklyn, N. Y. Laparotomy for the

removal of both ovaries and tubes, in three cases. All recovered. P.C. recovered, 100.

Prof. Lawson Tait, England. Enumerates eight cases of abdominal section for acute peritonitis with two deaths. P. C. recovered, 75; mortality, 25.

Prof. Joseph Eastman, M.D., Indianapolis, Ind. His first abdominal section was on Nov. 17, 1883. From July 1885, to Oct. 27, 1887, he performed thirty-four consecutive laparotomies, without a death. Dr. Eastman has a record of fifty cases with but four deaths; that would be a low rate of mortality; only 8 per cent.

In Dr. Eastman's seventy-five tubal reported cases, he has had nine deaths, attributable to the disease, mainly—plus the operation. Dr. Eastman is a remarkably successful operator. P.C. recovered 88; mortality, 12.

Prof. Eastman claims to be the first person to test a breakage in the alimentary canal by hydrogen gas; the test was made by him Sept. 27, 1887, and published in the *Journal of the American Medical Association*, Dec. 31, 1887.

Dr. S. C. Gordon performed laparotomy, Sept. 23, 1887, and found a gestation sac in the left Fallopian tube. The operation was closed sixteen hours after rupture. All signs of peritonitis left the case almost immediately, and patient made a good recovery. P.C. recovered, 100.

Dr. B. A. Kinlock performed laparotomy Aug. 31, for removal of a large myoma of the uterus. About Oct 15, the patient returned home in good health. P.C. recovered, 100.

Dr. Geo. R. Fowler, Brooklyn, Nov. 26, 1886, diagnosed an unruptured extra-uterine gestation, then located in the right broad ligament. Through a four-inch median incision, he found a seven-months foetus. Nothing untoward occurred, and patient made a rapid recovery. P. C. recovered, 100.

Dr. W. J. Sinclair. A ruptured sac in the early stages of a tubal pregnancy. From excessive hæmorrhages, pa-

tient become pulseless and nearly collapsed. Laparotomy. The amount of blood that flowed out was enormous. Sac burst four days before operation. Patient gradually recovered. P.C. recovered, 100.

Dr. Herbert W. White. Laparotomy for latent peritonitis. Tumor very large. Adhesions were universal to the abdominal wall, bowels and pelvis. Cyst multilocular, filled with pus and grumous blood, emitting a fetid odor. Recovered. P.C. recovered, 100.

Case 2. Prolapsed right ovary. Laparotomy, for removal of ovary on June 30, 1886. In September was well. P.C. recovered, 100.

Case 3. Was first seen July 19, 1887. Exhausted, cachectic. Suffering great pain. Pulse 120. Temperature 102°. Abdominal section was performed July 22, 1887. A scirrhus tumor weighing two ounces was removed from the right corner of the womb. After operation, vomiting, and was collapsed. The case seemed hopeless. Third day began to amend and made good progress to recovery. P.C. recovered, 100.

Dr. A. J. Bunker. Miss J. presented the characteristics of a uterine and ovarian tumor. On opening the abdomen, a fibro-cystic tumor of the uterus was found; that was impossible to remove. Wound closed and a drainage tube fastened to the wound. Was taken from the table almost moribund. Temperature fluctuated between 100° and 104°, until she died Dec. 6. P. C. mortality, 100.

Dr. J. F. W. Ross. Abdominal pregnancy, full term. Mrs. H. became suddenly ill, Sept. 26, 1886. Blood passed per vaginam. Swelling in the right iliac region. Breasts hot and large; milk, and caked. First felt life Nov. 1886, and continued to feel it till April 15, 1887. This date the pains were very severe, and the milk left the breasts. April 29, 1887, pieces of decidua were passed from an empty womb. Temperature 101°. Pulse 130. A second opening was found during vaginal examination into another uterine

cavity, which proved to be a case of *uteri-bicornis uni-cornis*. Incisions seven inches long. Delivered a male child, weighing nine pounds. Made a rapid recovery. P.C. recovered, 100.

G. M. Southwick, M.D., Boston. Reports three laparotomies for posterior flexion of the uterus and ventral fixation to the abdominal wall that resulted in perfect satisfaction to the operator and his patient. P. C. recovered, 100.

To tautologize, the real test, after all, that can be said for medicine and surgery is, the clinical results!

THIS IS THE TRUE STANDARD FOR ONE'S JUDGMENT!

Tait, again, has the credit of having performed one hundred and thirty-nine consecutive laparotomies without a death. P.C. recovered, 100.

Kieth has a record of eight such cases. P. C. recovered, 100.

Prof. Wm. Goodell, Philadelphia. One case of complete removal of ovaries. Recovery. P. C. recovered, 100.

Dr. Edward von Donhoff, Athens, Georgia, stercoraceous vomiting. Temperature 105°. Resorts to laparotomy and found an intussusception near the cœcal valve of 14 inches in length. Excision of the gut; closed with a modified Lambert suture. Patient made a good recovery. P.C. recovered, 100.

Case 2. A strangulation of an old right inguino-scrotal hernia. The coil of gut was nine inches long. Patient in extreme shock; survived the operation but fourteen hours. P.C. mortality, 100.

Dr. Montgomery, Philadelphia. Performed laparotomy on Mary G. for ovarian papilloma. Recovery satisfactory. P.C. recovered, 100.

Case 2. Laparotomy for an operation which proved to be a hæmato-salpinx. From appearance and history, he believed that an extra-uterine pregnancy had ruptured, causing a hæmatocele. Recovery. P. C. recovered, 100.

Mr. G. G. Bantock, *British Med. Jour.*, June 30, 1888, reports a case of laparotomy in which the adhesions were very extensive and hæmorrhage profuse. Operation lasted one hour and a half. Patient died on sixth day. P.C. mortality, 100.

Mr. Bantock reports eighty-two other laparotomies for removal of ovaries and other causes, such as tumors, etc., without a death. Adhesions existed in fifty-four cases. In thirty-four cases both ovaries were removed. Warm water not specially prepared was freely employed to wash out the peritoneal cavity, whenever the contents of the cyst had escaped into the cavity. Remarkable! P. C. recovered, 100.

Dr. Trenholme reports, in the *Montreal Med. Jour.*, July, 1888, seven consecutive and successful oophorectomies. P.C. recovered, 100.

Dr. P. J. Murphy, Columbia Hospital, Washington, D. C., reports two ovariectomies. First case: Both ovaries were removed for ovarian neuralgia. Discharged well, Dec. 10, 1887. Had been under observation up to July 1, 1888. Had not menstruated or suffered pain. Had never had any sexual desire either before or after the operation. P.C. recovered, 100.

Number two was a case of nymphomania supposed to be dependent on ovarian disease. On May 18, 1888, she returned to the hospital and stated that Dr. W. T. Howard had operated on her January 2, 1888; but that she was no better, and had menstruated twice since the operation; the first flow lasted thirty days. It is quite probable that some portion of the ovaries was left. Her sexual desires were as strong as ever, and there was no improvement in her symptoms. P.C. recovered, 100.

Dr. Chas. T. Parks, Chicago, has performed fifty laparotomies for ovarian tumors, with but two deaths. A fine record. P.C. recovered, 96; mortality, .04.]

Dr. H. T. Byford performed laparotomy on a negro virgin, æt. 32, for a fibro-myomata of the uterus. She re-

covered with no unfavorable symptoms. P.C. recovered, 100.

Dr. E. C. Dudley has performed fifteen laparotomies during the past year (1887) for the removal of the uterine and ovarian and par-ovarian cysts. Recoveries good. P. C. recovered, 100.

Wednesday, April 11, 1888. Dr. G. G. Bantock, four laparotomies.

Case 1. Cirrhosis of the ovary. Complete success.

Case 2. Salpingitis associated with an ovarian tumor with a twisted pedicle. Patient was married; æt. twenty-five. A success.

Case 3. Abscess of the right ovary with salpingitis and adhesions. Chronic salpingo-ovaritis on left side. Operation a complete success.

Case 4. Hæmato-salpinx and pro-salpinx. Single woman, æt. twenty-four. The patient was progressing favorably, and can be considered a success. P. C. recovered, 100.

Dr. Fancourt Barns exhibited a left Fallopian tube which he had removed six weeks before. The patient left the hospital on the third week. P.C. recovered, 100.

Thursday, May 3, 1888. Dr. Joseph Price reports the case of a lady who had passed through *two* operations—laparotomy. First time for removal of the left appendage and an ovarian cyst. The second operation was for a like process on the right side. On the ninth day her temperature was 102°, and from that time she presented a typical case of typhoid fever. Patient made a good recovery in the latter case and is now in full health. P. C. recovered, 100.

Dr. Wm. Goodell operated for a hæmato-salpinx which burst just before the operation. It was thought to be a case of tubal pregnancy at first. The woman recovered promptly. P.C. recovered, 100.

Dr. Goodell also presented a specimen of fibro-cystic tumor of the womb. The cyst was multilocular, weighing

33½ pounds. Drainage tube was kept in eleven days. Recovery was prompt. P.C. recovered, 100.

Dr. J. M. Baldy operated for a case of fibroid tumor weighing six pounds. Recovery. P.C. recovered, 100.

In four months he performed ovariectomy on same patient who survived this second operation. But in six weeks it became necessary to perform abdominal section for the third time for purulent peritonitis, and after this third operation the patient died; probably more from the peritonitis than from the operation.

Dr. B. F. Baer. Laparotomy Nov. 22, 1886, on a girl of 17 years, for an ovarian abscess. Her recovery was remarkably rapid. P.C. recovered, 100.

OPERATIONS AT THE GYNÆCIAN HOSPITAL.

I.—Abdominal section, June 23, 1888. Removal of right tube and ovary. Left appendages normal. Irrigation and drainage. Operator, Dr. Price. Convalescent.

II.—Had been in labor three days, attended by a midwife. Abdominal section, June 25, 1888. Removal of mass, right side involving bowels and omentum; was firmly adherent to abdominal wall, right iliac fossa, bladder, and uterus. Dr. Price, operator. Came out all right.

III.—Extra-uterine pregnancy. Placenta, sac, walls, tube, and ovary removed June 28, 1888. Two days after the operation the patient underwent the throes of labor and passed a complete decidua. Recovery. Dr. Price, operator.

IV.—Miss S., æt. twenty-one; never pregnant. Examination showed a mass size of child's head. Movable. Very tender. Abdomen tympanitic. July 1, 1888, abdominal section showed the mass firmly adherent to abdominal walls in right iliac and lumbar region. Cæcum, ascending colon, and several feet of small intestines were involved. Resection of twenty inches of large and small intestines. A small portion of the bladder was unfortunately removed

with the mass. Died in twenty-six hours from exhaustion. Dr. Price, operator. P. C. recovered, .75; mortality, .25.

E. W. Cushing, M.D., Boston, reports in *Annals of Gynecology* for August, 1888, twenty-one laparotomies for ovarian, par-ovarian cysts, purulent peritonitis, fibroid tumors, salpingitis, and other abdominal diseases, with seven deaths. P. C. recovered, 33.3; mortality, 66.6.

A. H. Golet, M.D., N. Y. August 25, 1887, performed laparotomy for an encysted sub-peritoneal hæmatocele. Recovery. P. C. recovered, 100.

Dr. C. B. Penrose reports, *Obstet. Gaz.*, Sept., 1888, two cases of extra-uterine pregnancy. Laparotomy and recovery. P.C. recovered, 100.

Dr. A. E. Morrison, *Edinburgh Med. Jour.*, reports: *Diagnosed* an extra-uterine pregnancy. *Confirmed* by an operation. Patient recovered. P.C. recovered, 100.

G. E. Kelsey, M.D., *Nashville Jour. of Med. and Surg.*: Pregnancy complicated by tubal pregnancy. He says: "I think both ovaries were impregnated at the same time, and I think this was a case of true twins. Patient died. P.C. mortality, 100.

Thos. Keith, M.D., Royal Infirmary, Edinburgh. *Fort Wayne Jour. Med. Science*, April, 1888. Twenty-six cases of abdominal section for hysterotomy and removal of appendages, from Jan. 1885, to August, 1887, with four deaths. P. C. recovered, 84.6+; mortality, 15.3.

Prof. Albert Vanderveer, M.D., presented before the State Medical Society of New York, Feb., 1888, the "History of Seventy-five Abdominal Sections in Albany," from Dec. 10, 1849, to Dec. 2, 1887, with thirty deaths. P.C. recovered, 60; mortality, 40.

INTRA-LIGAMENTOUS TUBAL PREGNANCY.—SUCCESSFUL REMOVAL BY ABDOMINAL SECTION OF A FOUR-POUND LIVING CHILD WITH ALL ITS APPENDAGES.—THE MOTHER WELL!—CHILD LIVING AND WELL ON DECEMBER 10, 1888.—See accompanying illustration from photograph of mother and child.



Mrs. C. and child. Right Tubal Extra-Uterine Pregnancy. Eight months' fetus. Operation performed July 10, 1888, by Prof. Eastman, M.D., Indianapolis, Ind. Child and mother alive and well December 10, 1888. Child weighing at that date, nine pounds. See page 414.

Prof. Joseph Eastman, M.D., Indianapolis, admitted to his private hospital on July 9, 1888, Mrs. C., æt. thirty-nine, and operated July 10, 1888.

Inspection showed tumor extending from near pubes, upward, on the right and reaching the liver. There was three inches of adipose tissue, so that the foetal heart-sounds were not detected. Breasts were not enlarged nor areola around the nipple.

Abdominal section revealed extra-uterine tubal pregnancy.

The tube seemed to have much of the right broad ligament surrounding it, as if the tube had originally been below the peritoneal fold of the broad ligament. The sac was dark purple, and tore open easily. The placenta was nearly under the line of abdominal incision. Any manipulation of sac caused hæmorrhage. Dr. Eastman at once removed tube and placenta *en masse*. Then began by separating an adherent intestine and omentum. Used pressure forceps, and ligated five times before he could surround the tube with his fingers. He applied the Eastman clamp below the fingers around the neck of the sac. This arrested all bleeding. Then he cut off above clamp and quilted iron-dyed silk into the pedicle which the clamp had made for him, using the cobbler's stitch. He washed out the peritoneal cavity with pure water, 105° Fahrenheit, three times, and put in a drainage tube. Patient suffered but a little from shock. The highest temperature was 102°.

Drs. Todd, Waterman, and Elder, who were present at the operation, examined the tube and child; all concurring in the belief with Prof. Eastman, that the child was an eight-months child, and *that the tube in this case had not ruptured.*

The lady made a good recovery; looks intelligent and well, as photograph shows. The child on December 10, 1888, was well, "never having been sick one moment," and was growing as nicely as any infant could grow. The child is now over five months of age, and weighs nine pounds.

It may be proper to add that Prof. Eastman informed the writer, by mail, that the abdominal wound healed by first intention, except where the drainage tube was inserted. Was in the hospital but twenty-seven days. The doctor says, "The sac was beginning to decay. The case had been under my observation one week. *Her symptoms were critical!*"

The Professor declined to pass a too decided judgment on the case before incision, for the reason that her former medical attendant had expressed so many different opinions, including one that "he, himself, was once in a similar condition, from eating too many grapes." P.C. recovered, 100.

The writer has been unable to find but three other cases that were similar to Prof. Eastman's.

First one, 1816. Edisto Island, S. C. Dr. John King. Operation at maturity; placenta removed; *woman and child saved!* Variety probably subperitoneal. *New York Medical Repository*, 1817, p. 388.

Second one, 1881. Dr. F. H. Mathieson, St. Mary's, Ontario, Canada. Fœtus mature; placenta removed; variety probably as Dr. King's. *Woman and child saved!* *Lancet*, May 24, 1884, p. 940. These two cases were collated by Dr. Robert P. Harris of Philadelphia. P.C. recovered, 100.

Third case reported in the *American Journal of Medical Sciences*, Feb., 1888. P.C. recovery, 100.

It is reported, and undoubtedly true, that Sir Spencer Wells has performed some 1500 laparotomies, and it is commonly reported of Prof. Lawson Tait that he has opened the abdominal cavity over 2000 times; but what the per cent. of mortality has been in these thirty-five hundred operations, the writer does not know.

We have herewith recorded one thousand and sixty-nine (1069) laparotomies, performed for the curative treatment of various pathological conditions of the abdominal cavity, attended by one hundred and fifty-nine (159) deaths; being

at the rate of 14.8 + per cent. It has been the purpose of the writer to exhibit the exact facts, whether they were, or were not, favorable to that most valuable operation, laparotomy.

These operations date back to those early days of December 10, 1849, when abdominal section was considered a most unwise and barbarous operation, down to July, A.D. 1888: very nearly thirty-nine years. How many valuable lives have been saved in ectopic pregnancy, by such a blessed surgical interference? An operation, born of the intelligence that cometh down from the Father of Lights!

In our researches, we have found five cases of ectopic foetation in which the foetus has, by the ulcerative process, found its way out of the abdominal cavity into the outer world.

CASE I.—Dr. John Pennefather reports a case in the *Manitoba Lancet*, July, 1888, which occurred in his practice twenty years ago, and that the lady was alive and well last July, 1888.

CASE II.—W. D. Hamilton, M.D., gives the history of a case in the *New York Medical Journal* of July 28, 1888. Patient died.

CASE III.—Dr. T. J. Woolf refers to a case in the *Cincinnati Medical News* of May, 1888, in which the patient recovered.

CASE IV.—Dr. Hunter McGuire presents another case in his practice in the *Virginia Medical Monthly*, August, 1888, resulting in recovery.

CASE V.—Dr. F. C. Vandervoort reports another case in the *Archives of Gynecology*, July, 1888, resulting in recovery.

Mortality in these five ulcerative cases, 20 per cent.

TREATMENT.

If extra-uterine pregnancy has been clearly diagnosed, there are presented two entirely different methods of treat-

ment, that are determinable by the condition of the patient ; that is to say, before or after rupture of foetal sac.

If rupture has taken place, there is but one legitimate method of procedure, recognized by every physician, and by every school of practice,—that is to say, laparotomy.

THE SIGNS AND SYMPTOMS of a ruptured extra-uterine foetal sac are *so plain, so patent*, with the great light that has been thrown upon such a condition by hundreds of intelligent practitioners, who all practically agree in their record of such symptoms, and the subsequent absolute proof, by ocular demonstration in many cases, that no one at all conversant with obstetrical practice, and *familiar with such a line of symptoms*, by observation or study, can easily fail to recognize a case of ruptured extra-uterine gestation.

Therefore, as has been affirmed in cases of a *ruptured* extra-uterine foetal sac, the *only* curative action in such a condition is to

PERFORM LAPAROTOMY for the purpose of removing the foreign bodies to be found in the abdominal cavity.

THIS IS AN OPERATION of such gravity, and requires a large experience ; so much so that the general practitioner does not consider himself competent to perform such operations. Therefore it would seem wise for the American Association of Obstetricians and Gynæcologists, or other body, to select favorable localities throughout the country, not widely separated, where the profession can find men eminent in the practice of gynæcology, who by long practice are competent to meet such emergencies.

TREATMENT BEFORE RUPTURE

May partake of a dual method, the one, by passing an electric current through the foetal sac, WITHOUT PUNCTURE, the other, by laparotomy.

THIS PAPER be as complete as would be desirable, did
WOULD NOT it not present an effective plan of treat-
ment for cases of extra-uterine gestation,
one not requiring the highest degree of surgical skill,
and that can be made available for one in general practice.

AN "EFFECTIVE is, electrical fœticide. "Effective" in
PLAN OF TREAT- that it—that is, the electric current—
MENT" will destroy fœtal life with the great-
est certainty in the earliest weeks of
extra-uterine gestation.

It is believed that the history of cases will show that
there is much greater success in performing laparotomy
after the death of the fœtus than before. Previous to
the death of the fœtus, the fœto-maternal circulation is
more active, more free.

AFTER THE DEATH one end of the *funis umbilicalis*, ter-
OF THE FÆTUS minating in the expanded placenta,
is less lively and industrious in cir-
culation than before death, so that, even on rupture of pla-
centa there is less liability of an effusion, because the whole
cord itself is less capable of transmitting blood. This is
reasonable, because it is a fact.

BUT, TO electrical fœticide, there is Dr. Thomas's ex-
RECUR TO perience, in which he has destroyed extra-
uterine gestation by electricity twelve times,
and lost no case. Others beside, to about the number of
seventeen or more cases, have met with the same results.
This shows a success of 100 per cent.

AFTER THE DEATH it is important to continue daily
OF THE FÆTUS applications of the electric current,
of from six to ten milliampères, to
stimulate the absorbents to take up the foreign abdominal
matter and thus cause it to be conveyed into channels that
are excretory, and thus remove the débris.

It has been claimed by some that the placenta con-
tinued to grow after the death of the fœtus.

Now, such assertions have not a shadow of physiological truth to support them. There is a stasis of blood current, to a greater or less extent, when one end of the cord has been made—the foetal end—inoperative by a destruction of function between the arterioli and capillary veins, that is to say, the extreme radicles of the arteries and veins in the foetus.

THE CIRCULATION FROM the maternal end must pass through the two umbilical arteries, then pass through the foetus, before it can be collected by the ultimate venous radicles, to be returned through the umbilical vein. How can this occur when there is an absolute arrest of function at one end of the circuit?

The writer is aware that there is hæmorrhage, even when the foetus is dead; but the sanguinous discharge must of necessity be less with one end of the cord in an abnormal condition.

HÆMORRHAGE COMES NOT SO much from the cord as from the ruptured or separated tissue between the placenta and texture to which the placenta is attached, which is retained on the primal support, and is filled very fully with moderate-sized arteries with patulous mouths.

After the circulation has stopped in the *funis umbilicalis* for some hours, there begins to be thrown out into the cavities of the above patulous vessels an organizing lymph, which in due time closes these canals. We have not, in such faulty conceptions, a good muscular wall back of the attachments, to contract upon the open canals and close them. Therefore, we must wait for lymph exudation and organization, while, at the same time this exudation—sweating out—of lymph, *does not organize into additional placental tissue, but into THROMBI! PLUGS!!* These thrombodes occur at the junction of, and in the placenta-supporting, maternal tissues.

IF EXTRA- pregnancy has been made out before rup-
UTERINE ture, what remains to be done?

In the opinion of the writer, it would be the wisest plan to stop such an unnatural gestation at the earliest moment. How? It seems to the writer that

ELECTRICITY given the first choice before rupture.
SHOULD BE The electric current is easy of applica-
tion, *it is certain in its operation*, and free from danger to the patient, and by its use the case has *not* been complicated in the least.

ANY PHYSI- possessing ordinary skill, can, in a very few
CIAN hours, prepare himself so as to pass a strong current through the foetal sac, and *effectually destroy its living contents*.

The negative electrode should be a metal ball, and the stem or holder of said ball should be insulated so as to protect other parts, and the ball carried up in the vagina or rectum to as near the extra-uterine foetal sac as possible. The positive pole should also consist of a curved metal plate, bent so as to approximate fairly to the abdominal contour, and covered with a piece of linen or chamois skin, dampened in quite warm water, so as not to shock the patient by a cold external application.

IS ELECTRICITY That is to say, is it certain to kill the
CURATIVE? foetus? The writer must reply, yes!

Not only Dr. Thomas has had twelve cases, but Dr. Mann has had four, and Dr. Stoddard one: that is, a total of seventeen cases, and NOT ONE FAILURE!

It is barely possible, that one may have a subsequent rupture, but so highly improbable as not to be worthy of any consideration. If such an event occurs, we have in reserve that wonderfully perfected operation, LAPAROTOMY!

ANOTHER exceeding rare is ulceration!

DANGER The number of such cases will not exceed .000218+ per cent. Or one in every 913.8 cases.

It is somewhat immaterial which current is used, whether it be the

FARADIC OR The galvanic, however, is somewhat preferable of the two, used with interruptions.
GALVANIC.

The current should be as strong as the patient can bear. If the patient is peculiarly affected by the current, and her symptoms are not changed in four or five days, then administer an anæsthetic, so as to be able to use a stronger current. From forty to sixty minutes should be used in each application. A current strength of from ten to twenty milliampères should be used, applied gradually, and increased to as much as the patient can bear. It must be plainly understood that a current strength must not be used that is capable of performing electrolysis, or chemical decomposition by electricity, of the parts in immediate contact to the electrode.

From four to six applications may be enough. But more—a dozen—may be necessary.

Signs of improvement would be, relief from pain, shrinking of the breasts, diminished tension of the cyst, and other improvements manifesting themselves. The action of the current is not one of electrolysis, but is strong enough to produce a nervo-electrical shock upon or through the fœtus, which is all that is desired.

As has been intimated before, that absorption of the foreign contents of the abdominal cavity will be hastened by a daily, and possibly a thrice daily, application of a modified electric current applied to the anterior and posterior walls of the abdominal cavity, thereby reducing the probability of an inflammation arising from a foreign body, and a possible septic poisoning.

SUMMARY.

It is believed not to be a very difficult and uncertain matter, now, to diagnose extra-uterine pregnancy *before* rupture.

The treatment that is proper and curative for that special time and condition is the electric current as above suggested.

After rupture has taken place, one is limited to the sole operation of abdominal section, as the *only* curative means that can engage the attention of an intelligent mind.

The reader will please note that the above one thousand and sixty-nine (1069) cases of laparotomy are not cited as new and unpublished, but are simply statistically arranged for the purpose of ascertaining the risk and mortality in so large a number of abdominal sections, so as to be of assistance to the careful and judicious general practitioner, who is ever solicitous for the welfare of suffering women.

THE THIRD STAGE OF LABOR.

H. D. CHAMPLIN, A.B., M.D., CLEVELAND, O.

There are at present three methods of dealing with the placenta:

First.—Pure expectancy.

Second.—Credé's method, or active assistance.

Third.—The Eclectic method, or middle ground between energy and expectancy.

Statistics show that Credé's method is employed by the majority of physicians, with good results.

Every obstetrician has had cases in which the placenta had been retained perhaps for two hours, but has it been of any advantage to have the membranes retained? Is it not rather a detriment? Have not many women's lives been *foolishly* sacrificed by waiting for the uterus to expel the placenta of its own accord, after protracted and abnormal labors?

What is to be gained by allowing a woman to lie hour after hour in her own blood, uncomfortable, anxious, and

in suspense, waiting for "Dame nature" to perform a part which common-sense should tell the attending physician to do himself? "Remove the placenta as quickly as possible."

Surgery teaches us to remove all foreign bodies from the human economy at once; their presence is a constant menace, and liable at any time to light up a train of symptoms difficult, and in many cases impossible, to cure.

The placenta is a foreign body, and why not follow out the same line of treatment?

My habit has been for the past ten years, as soon as the second stage of labor was completed, to place the left hand over the fundus of the uterus and make gentle pressure downwards and forwards, at the same time with two fingers of the right hand within the vulva make direct and gentle traction upon the cord, twisting the membranes as they made their escape into a rope, so that none might be left behind.

I always demand that a clean vessel be brought, into which the secundines are cast, and then at first opportunity examined to see that ALL are there.

In a ten years' comparatively large obstetrical practice, I have thus far failed to encounter that "bugaboo," a retained placenta.

ATRESIA VAGINÆ (CONGENITAL).*

BY H. A. WHITMARSH, M. D., PROVIDENCE, R. I.

Lizzie D., aged fifteen, a brunette, in stature undersized, had for many months suffered at regular intervals, with what seemed to be menstrual pains, but without flow. For the latter five months especially, each attack had exceeded the preceding one both in severity and duration, so that in August, '83, the pains lasted eight days. Morphine, ether, or chloroform had been necessary for relief.

* Read before the Boston Gyn. Club.

Though in this case there was no inflammation at the site of the incision, the wound healed by contraction and dilatation would be similar. On February 12, 1889, gave me a small amount of urine. Merely a slight crescentic swelling of the left of the vulva. Moderate retroversion of the uterus. The only abnormality was the urine. She herself well, and her appetite good.

SOME ANOMALOUS CASES OF VAGINITIS

BY R. LUDWIG

In women, contrary to the general opinion, inflammatory affections of the vagina are not so frequent. This fact has been proved by the liability of their sexual organs to certain diseases, and the susceptibility to certain others, of which either do not or rarely occur in men.

And not only are the diseases of the vagina frequent and varied in their character, but they are more so in our specialty than in the general practice, in that they are less easily cured. The reason for this is, I think, to be found between the structure of the vagina and that of the urethra, not of a fixed character, but of a variable one. I identify the lesion as a vaginitis, and not as a urethritis, that have already been cured, and that cases would be easily cured, and that they are readily cured.

There is no point in the treatment of the disease at the outset, it is more

* Read before the American Medical Association.

the supposed necessary relation between the inflammatory process or its consequences, and local disease and suffering from other and very different sources. On the basis of a large experience, I am confident that we ought to discriminate most carefully in obscure and obstinate affections of the urinary organs in women, to the end that we may apply the proper means of cure, whether they be medical or surgical, most skillfully and successfully.

With a view to facilitate the study of this class of cases and to warn my medical friends against the folly of treating them by a routine method, I most respectfully submit the following considerations:

Within the scope of this paper an anomalous affection of the urinary organs is one which deviates from the rule that a serious perversion of function must necessarily be accompanied by a change of structure. Most of these cases were formerly classified under the general head of irritability of the bladder because there was no constant, or consequent lesion of its tissues. And although, as in the case of Gooch's "irritable uterus," the word *irritability* has now lost very much of its clinical import, we may yet do well to retain it in connection with vesical troubles especially, and as a safeguard against the inflammatory *ignis fatuus* which has so often put the physician on the wrong course of treatment.

The limited number and similarity of the symptoms, as well as the varied causes of this order of urinary affections, have been so many stumbling blocks in the way of their cure. For they often bear so close a resemblance to those of organic disease as to be extremely deceptive and misleading. Indeed, without recognition of the peculiar cause upon which a given case of this kind may possibly depend, its clinical portrait can not be accurately drawn, nor can we prescribe for it intelligently. We need to know the source of the mischief before these equivocal symptoms can have their proper therapeutical significance. For not only are

will be only temporary, and a resort must be had to other and additional means of cure.

IV. *The Constitutional Causes* include those depraved and debilitated conditions of the general system in which there is a low vitality and an increased tendency to nervous affections generally. Anæmia is a frequent cause of this class of troubles, and whether it follows menorrhagia, too rapid child-bearing, or being overworked and underfed, as so many of our women are, the result is the same.

Every physician who is experienced in this line of practice and who has kept his clinical eyes open, has noted the proneness in some of these patients to the slighter forms of bladder trouble whenever they were chilled. In them the merest trifle in the way of a rigor would prompt the desire to urinate, and if they were not warmly dressed, in bad weather especially, the urinary mischief would easily be perpetuated.

This hint should be enough to suggest that malarial conditions might beget urinary mischief, and would therefore explain the occurrence of obscure cases of the kind in paludal districts, and in those who had once had ague. I could cite a number of cases that I have easily and readily cured by bearing this simple fact in mind, and by prescribing upon a clearly clinical indication.

Similar troubles of the urinary organs in women are associated with tuberculosis, especially if it has attacked the peritonæum or any of the organs within the pelvis, or if, in an obscure way, it is associated with either of the forms of diabetes.

The puerperal dyscrasia, the effect of repercussed eruptions and the hysterical diathesis are, also among the constitutional causes of these anomalous affections that are in no way associated with organic change or with the inflammatory process.

CLINICAL CASE.*

BY W. H. LOUGEE, M.D., LAWRENCE, MASS.

Mrs. B. was attacked with pain in her bowels in March, 1888, after being sick with her regular sickness four days. This pain continued ten days, when it disappeared, to return again in April, and lasted about the same time as in March. When taking cold or getting tired these pains would attack her for a few days, then leave again, until November, when it came on worse than ever before. Flow was of proper color until it had continued four days and a half, when it lost its red color and continued as profuse as before, but was yellow in color for ten days, when pain grew worse, and she was compelled to take her bed, where flow changed to red again, but the quantity was more profuse than usual, and lasted ten days; but every few hours she would experience severe attack of pain. Was chilly and feverish, appetite poor, bowels regular, but urine high-colored. Most pain on right side of bowels just above the bladder and a little to the right of the mesian line. Bowels so sore and lame she could not stand up straight, and walking about hurt her very much indeed. Any gas in the bowels would cause her great pain.

At this stage of her sickness her physician made an examination and passed a sound with much difficulty into the uterus. This examination, wise or unwise, gave her great pain and suffering. She fainted dead away and vomited profusely, and was so prostrated that she did not leave her bed for days. When she had recovered sufficiently to sit up, walk a little, and ride in the cars, she came to Lawrence and put herself under my care, which was the first of January of the present year.

On my first examination I found her face pale and pinched, lips white; thin in flesh; could not stand erect

* Read before Boston Gyn. Club.

without giving her much pain. Had been flowing every few days for a day or so, when it would check up, and then in a day or so break out again. Upon digital examination I decided from size of cervix that the uterus could not be much enlarged. Had so many misgivings about passing the sound that I did not do it, but could not make out that the uterus was very much enlarged, but it was fixed, and when I attempted to move it she would cry out from the great pain it produced.

In passing the finger up over and a little above the anterior cervix I discovered a swelling the size of a medium sized orange which was very sensitive to touch or pressure. This swelling and the body of the uterus seemed to be adhered to each other. Any attempt to move the uterus produced great pain in the region of this swelling. At first I thought the trouble was in the right broad ligament, then I thought possibly it might be caused by something in the shape of fibroids from the uterus, projecting out from the uterus and getting up disturbances in the peritonæum. But I finally decided that let the cause be what it might, my first duty was to cure the local inflammation and relieve the pain.

Patient was ordered to bed, all motion or exercise strictly prohibited, bowels packed in water, alcohol, and Pond's Extract, equal parts, and put on belladonna and merc. sul. She took three hot douches of several quarts three times a day. Bowels were kept open every day. After four days of this treatment, I made another examination which revealed just about the same condition as my first, with the exception that there was not quite so much heat, tenderness, and pain as on the first examination, but if any change in swelling I thought it slightly increased. At this time I changed the treatment and gave bryonia and merc. sol. in alternation every two hours; also painted the bowels over the swollen and painful part with tinct. of iodine and over that applied a hot poultice which was to be renewed

every four hours. Into the last pint of her douche I ordered twenty drops of iodine, and under this treatment she improved daily until all pains had ceased in her limbs, soreness mostly gone from the bowels, fever gone, appetite good, and external pressure produced but little pain. After one week of bryonia and merc. sol. I gave four drops of syr. iodide of iron after meals.

February, 1889, examination fails to find any heat, tenderness, swelling, or pain in the region where the trouble existed. Patient has gained much in strength, in flesh and in her general appearance. Stands erect, walks without pain, and so far as I can see is in perfect health.

TREATMENT OF INSANITY OF PREGNANCY.

BY H. H. CRIPPEN, M.D., SAN DIEGO, CAL.

(Concluded from page 331).

Bromide of potassium.—Dr. E. M. Hale gives the following: "*Puerperal mania* when attended by ferocious or erotic delirium." He advises its use in minute dose, 3 x to 6 x, in mental depression from cerebral anæmia or exhaustion.

The pathogenesis of kali bromatum is suggestive of dementia. Possibly we may find it of use in such conditions.

Chamomilla.—Mental erethism. Angry and out of humor. Cannot bear to be spoken to or interrupted. Slight irritations of the mind produce great anguish and distress. Inclined to be quarrelsome; she seeks a cause for quarreling. Irritability even amounting to incivility.

China.—Mania following hæmorrhage or after prolonged lactation. Excessive sensitiveness of the whole nervous system, debility, exhaustion, intolerance of noise. Extreme anxiety and apprehensiveness. The patient sees persons and objects on closing the eyes, these disappear as soon as the eyes are opened (calc. ost., bell).

Cuprum aceticum.—Cuprum metallicum appears to have been a reliable remedy in mania in Dr. Jahr's experience,* but I place greater confidence in the acetate, in the following condition: Mania appearing in paroxysms. Confused look; at times she is in apparent full possession of her mental faculties, yet is liable to paroxysms of howlings which come suddenly and unexpectedly.

Hyoscyamus niger.—In Vol. II. of Hempel and Arndt a case is given from *Frank's Magazine* in which hyoscyamus exercised curative powers. "A lady of sanguine choleric temperament, aged thirty years, had been confined without any untoward incident. Shortly after her confinement she took cold, one of her breasts became inflamed, and the flow of milk and the lochial discharge were very much diminished. Her medical attendant found her with the following symptoms:

Breathing short, pulse feeble and contracted, 120; tongue somewhat coated; urine dark yellow, stool regular, great heat; no appetite or sweat; head red and bloated; eyes unsteady, conjunctiva injected, the right breast inflamed, red and hard. Suddenly she would jump out of bed, crying: 'I cannot sleep, I shall die anyhow.' She knew everybody present, but was enraged, attempted to bite, uttered the most piercing cries, and manifested superhuman strength so that it took seven persons to hold her.

She took the extract of hyoscyamus in one grain doses every hour; the paroxysms yielded in a short time and at the end of twelve days the patient was again able to attend to her domestic duties."

We have also the case reported by Dr. H. H. Hofmann.† "Primipara of thirty years. Labor slow but normal. About the seventh or eighth day she showed an aversion to her child, her husband, and her nurse. She would run through the house in a nude state, and, as it was winter,

* "Forty years' Practice," 1869.

† Op. cit p. 391.

she got a very severe suppurative mastitis of both breasts. She was greatly troubled with incarcerated flatulence, which was relieved by reversing the action of a Davidson's syringe and pumping her out. She was given hyos.", but as this did not relieve her as promptly as expected, she was given the tincture, which relieved."

Hyoscyamus seems to be especially adapted to acute mania in which there is excitation without any evidence of inflammation. The symptoms as given by Farrington* will apply equally well for our purpose. "The patient under such circumstances has many flexible notions, all arising from these morbid impulses. He imagines, for instance, that he is about to be poisoned. Possibly he will refuse your medicine, declaring in angry tones that it will poison him. Or he imagines that he is pursued by some demon, or that somebody is trying to take his life. This makes him exceedingly restless. He springs out of bed to get away from his imaginary foe. The senses, too, are disturbed. Objects look too large or else are of a blood-red color. Sometimes objects appear as if they were too indistinct; that is they have an unnatural sharpness of outline. The patient talks of subjects connected with everyday life, jumping from one subject to another pretty much as in lachesis; all this time the face is not remarkably red, possibly it is only slightly flushed. The pupils are usually dilated, sleep is greatly disturbed, the patient lies awake for hours.

"At other times we find the delirium returning anew and the symptoms take another form. The patients are silly and laugh in a flippant manner. Sometimes, for hours at a time, they will have a silly, idiotic expression on the face. Agaid they become lascivious, throw the covers off and attempt to uncover the genital region. The abnormal movements accompanying these symptoms are rather

* "A Clinical Materia Medica," 1887, p. 384.

angular; they are not at all of the gyratory character of stramonium."

Ignatia.—Melancholia; despairs of her salvation; imagines she has been faithless to her husband; weeping bitterly; tenseness of the abdomen; cold hands and feet; desires to be alone with her grief.

Lilium tigrinum.—In comparison with sepia Dr. S. H. Talcott gives the following indications. "Lilium and sepia find an important place in the treatment of depressed and irritable women. The troubles in such cases originate largely in the mal-performance of duty on the part of the generative organs. Both lilium and sepia cases are full of apprehensions and manifest much anxiety for their own welfare. In the sepia cases, however, there are likely to be found more striking and serious organic changes of the uterine organs; while the lilium case presents either functional disturbance or a very recent and comparatively superficial organic lesion. Lilium is more applicable to acute cases of melancholia where the uterus or ovaries are involved in moderate or subacute inflammation, and where the patient apprehends the presence of a fatal disease which does not in reality exist. The lilium patient is sensitive, hyperæsthetical, tending often to hysteria. She quite readily and speedily recovers, much to her own surprise, as well as of her friends, who have been made to feel by the patient that her case was hopeless. The sepia patient is sad, despairing, sometimes suicidal, and greatly averse to work or exercise. There is, however, often, a good reason for the patient's depression, for, too frequently, she is the victim of profound organic lesions which can, at best, be cured only by long, patient, and persistent endeavor."

Opium.—Furious mania, with distortion of the features, bloating and redness of the face, bluish redness and swelling of the lips. Exalted imagination; frightful visions of ghosts, demons, and horrid beasts.

Platina.—Very proud and haughty. Excitation of the

sexual passions, with voluptuous crawlings and tingling in the genitals, nymphomania. Melancholia; thinks she is not fit for the world, is tired of life, but has a dread of death. The feeling of great personal superiority is the manifest characteristic of Platina. Persons are looked down upon as inferior, and insignificant. "She is out of sorts with the world, for everything seems too narrow." "*Objects about her look to be smaller than natural.*"

Pulsatilla.—Depression of spirits; sad, weeping mood; solicitude about her salvation; disposition to suicide, but fear of death; chilliness, flashes of heat, cold hands and pale face.

While the lachrymose symptoms of *Pulsatilla* are, in the main, characteristic, this drug must be compared with others that have the "weeping mood"; among these we have *ignatia*, *natrum mur.*, *stannum* and *sepia*. For the purpose of comparison, we may study Farrington with great advantage.

The *ignatia* woman dwells upon her grief in secret, she nurses her sorrows and keeps them to herself. In the words of Shakspeare she lets, "Concealment, like the worm i' the bud, feed on her damask cheek." This introspective mood is the opposite of *pulsatilla*. The *pulsatilla* patient makes known her grief to every one who comes near her. She seeks sympathy. She is timid and yielding in her disposition.

This tender yielding disposition, that likes consolation, differs from *natrum mur.*, in which, with hypochondriasis, consolation seems to make the patient worse. Attempts at consolation may even make her angry.

The *stannum* patient is usually sad and lachrymose, just like *pulsatilla*. Crying usually makes the patient worse. The woman for whom *stannum* is indicated is also nervous and weak. *Stannum* will come in as a prominent remedy in lung troubles complicating insanity of pregnancy.

Sepia also develops a state of weeping, anxiety with

ebullitions, peevish ill-humor, solicitude about her health. But with all her lachrymose temper she is easily offended and is inclined to be vehement.

Stramonium.—The mania of this drug may be of a wild, or of a merry character. Delirium with bright-red face; the eyes have a wild and suffused look. Terrifying hallucinations; the patient sees animals springing up from every corner. Loquacious delirium; at times a merry mood; at others he has the horrors. Laughing, singing, and making faces one minute; the next praying or crying for help. Desire for company and for light, with fear of the darkness.

In the *New England Medical Gazette*, of May, 1871, Dr. G. N. Brigham reports a case cured by stramonium. "Called to see Mrs. B., a light blonde, aged twenty-six. She was delivered six days since. Found her in an ecstasy, singing, clapping her hands, and breaking out into boisterous expressions, such as, 'Oh, how happy I am,' etc. She would seize every one by the hand, showing great pleasure on meeting; would talk about going to heaven, of being dead and laid out in black. Says she is the handsomest corpse that ever was; refuses to nurse her child, saying it, too, was dead. Accuses her husband of infidelity, and all women around of being guilty of criminal conduct, yet speaks lightly of it, and accuses herself of previous wantonness. Find some tenderness about the pubes. Prescribed stramonium. Convalescent next day."

Farrington gives the following comparisons, which show at a glance the relative value of stramonium, hyoscyamus, and belladonna.

"Stramonium differs from belladonna and hyoscyamus. The patient sees objects which seem to rise in every corner of the room and move towards him. He has a mania for light and company, which is just the opposite to belladonna, is excessively loquacious, and laughs, sings, swears and prays, almost in the same breath. The desire to escape is present; there is sudden spasmodic lifting of the head from

the pillow, and then dropping it again; he awakens from sleep in fright and terror, not knowing those around him; the motions that he makes are quite graceful and easy, although they may be violent. At times the body is bathed in a hot sweat, which does not give any relief to the patient. The desire to uncover is similar to that of hyoscyamus, but it is more an uncovering of the whole body than of the sexual organs. The tongue is often soft, taking the imprint of the teeth; screaming in sleep, often with hiccough; the face is usually bright red, but not so deeply congested as in belladonna."

Sulphur.—Despondency; religious melancholia, with despair for her salvation; irritable and taciturn; slowness of body and mind during the day; indisposed to do any labor. Mania; she spoils her things and throws them away, imagining she has everything in abundance. She imagines she has beautiful dresses; looks upon old rags as beautiful dresses.

Veratrum album.—Furious mania; wild shrieks, protrusion of the eyes, bluish and bloated face, anxiety, frightened at imaginary objects, lasciviousness, lewdness in talk, endeavors to kiss everyone. Coldness of the surface of the body with cold sweat on the forehead.

Veratrum viride.—Mania with arterial excitement. Eyes red; pulse small but very frequent. This drug has been used in a case of acute mania with curative effect after hyoscyamus, stramonium, veratrum album, and hepar had been in vain.* The following symptoms were present: Loquacity with exaltation of ideas, or an exalted opinion of her own ideas and powers; everything seems clear to her; what had formerly been mysterious to her, she now clearly undertsands. She does not want any medicine that will restore her to her former condition. Some of the time she talks and laughs. On some days the laughter is quite constant. One day she talks a long time about one thing

* "Materia Medica and Therapeutics," Hempel and Arndt, Vol. II., p. 888.

and again changes that theme to some other. Will persist in continuing to talk, without giving any attention to what is said to her. Will not answer questions; does not like to be disturbed while she is talking. She knows all that is going on about the house, and does not want anything said which she cannot hear. Does not want to get up long enough to have the clothes changed. Head feels bad. The eyes are red, but vision is not affected, appetite capricious; not much thirst; pulse small and frequent." The tincture of veratrum viride cured the patient.

In one of Dr. Atlee's cases the patient was stubbornly silent, suspicious and distrustful of those about her. She thought the physician had poisoned her, meditating her destruction.

A CASE OF CHRONIC INVERSION OF THE UTERUS.

BY M. W. VAN DENBURG, A. M., M.D., FORT EDWARD, N. Y.

It is now about six months since I first reported the case of Mrs. G. in this journal.

By referring to the paper, it will be seen she claimed to have suffered from complete chronic inversion for about seven years previous to the reduction. The ball-club pessary there described was used for about three months, when the walls of the vagina began to sag and protrude beyond the vulva. Besides, the weight of the uterus resting upon the end of the pessary, seemed to produce soreness and local pains, judging from the reports of the patient.

A ring, supported on a stem, was therefore substituted, but with only partial success, as it could not be readily retained in place. Finally a ring larger than the first was lashed to the upper side of the stem-ring, and thus constructed, presenting a broad supporting surface with sufficient central space to allow the mass above to rest firmly

upon the supporter, it has been found all-sufficient. No discomfort at all is experienced with this pessary, and the lady walks and goes about her usual avocations with no inconvenience.

There is not, nor has there been at any time, any vaginal irritation, leucorrhœa, or other discharge from the restored mucous membrane. The tissues remain of about the same redundancy as when first reduced, not having shrunk to any morbidly appreciable extent. The mucous surfaces are moist, normal in color, showing no abnormal tendencies that I have observed. One would scarcely expect so few annoying symptoms and so little systemic trouble from malposition so extreme, in the case of an organ prone to produce all kinds of nervous reflexes.

INSTITUTE ETCHINGS.

T. GRISWOLD COMSTOCK, M.D., St. Louis.—I am convinced that a large proportion of gynæcological practice comes from gonorrhœa. When my patient is a married woman, the disease innocently acquired, and when I find she already has a salpingitis, my treatment is galvanism, and my success with this agent during the past year has been wonderful. It is efficient when nothing else will do good.

R. LUDLAM, M.D., Chicago.—I believe there is one recourse in the treatment of gonorrhœa of the female which should be given special mention, and which has done more good in my experience than any other agent. It is the simple use of hot water hip baths, which can be assisted by hot water injections in the vagina, and this should be repeated two or three times a day, possibly oftener in some instances. I don't believe in nor use strong caustics.

C. B. KINYON, M. D., Rock Island.—I have obtained the best results in the treatment of acute cystitis with a 10 per

cent. solution of the nitrate of silver, touched upon the vesical fissure. I sometimes stretch the sphincter with a steel sound.

O. S. RUNNELS, M.D. Indianapolis.—I protest against the use of nitrate of silver locally in these cases. I depend upon electricity, the application of galvanism, and in conjunction the indicated remedy, aconite, bell., canth., cannabis, and others.

A. CLAYPOOL, M.D. Toledo.—There is the greatest necessity in all pelvic troubles of making the diagnosis thorough and decided, and of understanding the pathology. A very similar symptomatology results from inflammatory affections of the bladder, whether from mechanical or other irritable causes. Exercise the greatest care, therefore, in making of diagnosis.

A. C. COWPERTHWAIT, M.D., Iowa City.—There is a competent remedy for nervous reflections of the bladder, that variety which is of daily occurrence. It is gelsemium. In a case of a lady who could not urinate when any one else was in the room, gelsemium promptly relieved.

H. C. LEONARD, M.D., Minneapolis.—In a hyperæsthetic condition of the urethral canal, I prescribe lachesis, 10th to 200, and have had no failure when that was the principal symptom.

E. M. HALE, M. D., Chicago.—The arrest of a physiological process, like the arrest of the secretion of milk, is a matter for discussion outside the domain of our therapeutics and of any homœopathic remedy as such. We must use such means, whether mechanical or therapeutical, as will arrest that physiological process and prevent its going on to a pathological condition. In regard to the bandages, I have been disappointed in, and do not use them. I substitute a belladonna plaster, which unites both the mechanical with the medicinal principle. Belladonna acts upon

the secretory function of all glands to prevent their normal secretion; so far belladonna ought to be one of the foremost of remedies. I have sometimes failed with it and have substituted antipyrine. The use of antipyrine is about two years old in my practice; before that I used to rely upon belladonna altogether. Camphor I discarded several years ago. I gave five grains every three hours, and this is my practice to-day where I wish to arrest the secretion of milk and prevent pathological engorgement. Of the diet we should exercise command and care. If the patient is of a delicate condition, and has lost much blood, we must reduce the diet or we shall not only check the secretion of milk, but we shall check other and important functional processes. A little meat should be allowed to such persons; if the patient be robust give dry toast and water. I generally keep the patient upon a strict diet for the first four days. In answer to a question I can ascribe no especial reason for the action of antipyrine in this class of cases; I have not made a proving of it; I know, however, that it checks the secretion of milk, and that I have never met with any unpleasant results. I would not advise larger doses.

Dr. BINSWANGER.—I had a case where antipyrine was indicated and given, and the lady reported that she had not sufficient milk. The medicine was stopped and the milk became plentiful. In a few weeks I had occasion to prescribe the same remedy with the same result; and since then in order to suppress milk I have used antipyrine, and it has always served me well.

WM. OWENS, Sr., M.D., Cincinnati.—I allow the milk to be developed up to the third day, encouraging it up to that period, and then make use of a single application to the breast of raw cotton scorched. I apply that hot to the breast. I have had no case of an abscess to the breast in twenty-six years. It will arrest the secretion of milk, and

what milk has already formed will flow out upon the cotton. Re-application to be made in four hours; depending of course upon the amount of secretion as to the frequency with which applications be made. I have had in rare cases to resort to camphorated oil. The application is made without compression, it keeps the breast warm and allows any secretion to flow out upon the cotton; in from five to eight days from that time the secretion is generally arrested.

B. F. DAKE, M.D.—In my earlier experience I resorted to various remedies and measures advocated, but latterly I have practiced the plan of masterly inactivity; let the breasts alone, and I believe that is the most natural way to treat them. Since using this plan of doing nothing except to support them when they are heavy, I have had no trouble with the breasts. There will be great pressure for three or four days, the milk will gradually subside, and in the course of ten days or two weeks the lady is entirely out of all discomfort and quite comfortable.

H. C. LEONARD, M.D., Minneapolis.—I have good results in preventing inflammation and other troubles by applying the cotton batting to the whole chest, covering in the breast immediately after the delivery or as soon after delivery as possible, certainly the first day. The effect is to prevent congestion and I have no doubt but that is quite sufficient in most cases to prevent trouble, as well as producing a curative effect upon the inflammation by reducing the congestion and thus obviating the forming of an abscess. This is especially true in breasts that have been bruised by the breast pump, or by the meddlesome interference of some rough-handed nurse, or a clumsy one, or by any other violent means. I believe, too, that there may be possibly some trouble in the climate, and that many of these cases of inflammation of the breast are from a septic cause; certain it is that we have more of those cases where the nipples are cracked and sore; and a good treatment for such cases

when the cotton is applied, is to cover the nipple in with dry powder of borax. When there is any tendency to sore nipples this same powder will serve to prevent them. In this latter case I should use both the scorched cotton and the boracic acid.

C. G. HIGBEE, St. Paul.—It is the exposure to which lying-in women are subject which causes the most of the inflammation and suppuration from which they suffer. Therefore protect their chests after confinement until after the flow of milk is established, and you will scarcely ever have any inflammation or suppuration.

L. C. GROSVENOR, M.D., Chicago.—We may look back a long way in many cases for the causes of inflammations and abscesses of the breast. When a girl is developing from girlhood to womanhood she is shy and sensitive to the least attempt to reach the conditions which may and do influence the proper formation of the breasts; and when these breasts begin to develop, she notices and tries to hide them. One of my patients tied a towel around her under her clothing to hide her breasts. Later the corset is applied and you have pressure again. When she gets a little older she finds these are a part of her charms and she wants them a little larger—then she begins to pad, a quite possible source of harm.

H. C. LEONARD, M.D.—One suggestion with reference to the use of the catheter. I believe that where you introduce a catheter in such a case as Dr. Leavitt's, it is best to use a large instrument. By doing this the first time you will not be likely to need to repeat it. I use a flexible one—one of the so-called silk woven catheters.

DR. BINSWANGER.—I emphasize the caution about using the catheter too soon. I place great store by the indicated remedy, usually *nux vom.*, to control the flow of urine.

H. M. HOBART, M.D., Chicago.—I believe that of all of the remedies commonly employed in retention of urine

hyoscyamus, which has not been mentioned, will relieve the majority of cases. Belladonna stands first in my experience and hyoscyamus next as the indicated remedy.

E. M. HALE, M.D.—Of a young woman in her first delivery, I had expected trouble, because she was hysterical and had a good many spasmodic symptoms. The first attempt to urinate, six hours after labor, was attended with so much exquisite pain that I forbade her to try any more and attempted to use a very small, soft catheter; but the very attempt to use it created so much fear of pain that I felt compelled to desist. Then I used for three or four hours common expedients with water, fomentations to the abdomen, running water from a height, etc., but with no effect. Then it occurred to me to try the effect of cocaine. Therefore with a medicine dropper, the only thing I had in hand, I injected twenty to thirty drops of the 2 per cent solution very carefully into the urethra. Two minutes later she was able to urinate without any effort whatever, almost without any knowledge except that it was running over the vulva. About every eight hours she would feel this intense desire to urinate, with great pain upon the slightest attempt before any water would pass, so that I had to use the same injection for three days, when the trouble began gradually to subside. I suppose it was an extra spasmodic symptom—spasm of the sphincter. I have known it to be used in spasmodic cases, and it is better than the catheter; for after a few applications of the cocaine we don't have to use anything, whereas with the catheter, it is sometimes a week before it is possible to re-establish the natural flow of urine.

DR. COMSTOCK.—Immediately after labor is the best time to repair the perinæum if ruptured.

DR. RICKER.—I consider Dr. Comstock's paper on Occipito-posterior Positions in Labor a decided advantage to obstetric art. I have also met with some of these cases,

and wish to emphasize the fact that it is a vicious position. Simpson has said that any obstetrician who is not able to remedy this position is not a proper person to practice this art. I have not been able to do it; nor was I able to deliver a certain case without some laceration of the perinæum. If I had known that the operation spoken of could have been practiced in those cases—I knew of that particular operation, of course, though not for this special trouble—I might have saved my cases, but I too supposed it an operation that young physicians only adopted. There are various reasons given by obstetrical writers why this rotation does not take place. Pajeau claims that rotation is the result of certain mechanical laws wherein one solid body contained within another being pressed upon from various directions, it will constantly tend to accommodate itself to the diameters of the containing body. This is all true, provided the conditions are favorable. But they are not generally favorable in these cases and consequently we very seldom get forward rotation spontaneously. I have used my forceps, and in no case was the child lost, but the maternal structures were not preserved.—Published in full in the *Am. Homœopathist*, August, 1889.

Dr. A. A. WHIPPLE, Quincy. — Recently at a Society meeting in my state I presented a paper which was called forth by that of Dr. Comstock published in the *Homœo. Jour. of Obstetrics*. I fully believe that this operation of epicystotomy is not necessary. The postero positions are certainly vicious enough, but I see no reason why this operation should be performed. They could be delivered, and I have had three cases. In two of them it took me three hours before I could accomplish delivery, one without a ruptured perinæum, the others were ruptured but easily repaired. With caution and due care, with proper assistance and in the last moment when the perinæum is distended, by being slow and especially cautious most cases will terminate without rupture, or if ruptured, you can

readily repair them as well as when a laceration is produced artificially. I am opposed to the operation also because no one can tell beforehand that there will be a rupture. Of my three cases one of the children lived, and two of them were dead when they were born.

B. BANTON, M. D.—I have had four such cases. In the first I took the advice of a number of authors and waited, waited until it was necessary for me to make some move. It was impossible for the child to be born, and I well understood then that the case was a vicious one. I put the patient under the influence of chloroform, introduced my hand into the pelvis, rotated the occiput, and in a few minutes labor-pains came on and the child was born, but was born dead. I am satisfied it died through my neglect in not acting before. The next case I diagnosed promptly and proceeded to turn, and the case got along nicely. The next was one where the child was not largely developed, the woman was in good condition, and the child was born without much trouble, but the head was unnaturally deformed, which however, corrected itself afterwards. The fourth case was one that I also turned on the diagnosis. With the experience that I had had, I could diagnose the case early and I turned it very quickly and without delay.

DR. HIGBEE.—The question is an important one, whether it is better to use the knife or to deliver without, and take the chance of rupture. I believe it best to deliver without resorting to the knife. It is not disputed that the position is a vicious one, and involves the necessity of a prompt delivery either with the hand or the forceps; in the latter case taking the chances of rupturing the perinæum. I would take the chance of rupture, because I believe that the wound would heal more quickly, or fully as quickly, and with less danger than it would if we cut.

SHELDON LEAVITT, M.D. In a number of cases of occipito-postero position in my practice I have never seen any

such as Dr. Comstock has described ; that is, I have never had a case where the occiput persistently remained backward and the head became impacted in the pelvic cavity or at the pelvic outlet. But I really feel that I have avoided just such complications as these in a number of instances by recognizing the character of the position early in labor, and adopting such measures as tended to bring about rotation of the head. In some instances the occiput rotates backward because we have not insisted upon the head maintaining the flexed position. If we insist upon keeping the occiput well in advance, resisting the advance of the sinciput, and drawing down with the finger to keep the occiput well down, we will do something to favor rotation of the occiput forward. After the head has gotten down into the pelvic cavity, where it is clear of the superior strait, if there were no reasons for early interference before the head had entered the superior strait, I then apply the forceps, usually the long forceps of ordinary construction with the pelvic curve, and remembering the double curve of the instrument I then rotate forward the occiput. I have done this in a number of instances with entire safety to both mother and child. First recognize the character of the position early in labor as possible. In two instances I have felt called upon to use the forceps when the head was still above the superior strait. In those cases I have succeeded. In one of them I succeeded by manipulation in rotating the head above the superior strait until the long diameter of the head lay transversely at the brim ; then I applied the forceps to the sides of the pelvis embracing the head over an oblique diameter, drawing it down into the pelvic cavity.

MASSACHUSETTS SURGICAL AND GYNÆCOLOGICAL SOCIETY.

The Semi-Annual Meeting of this society was held at Hotel Thorndike, Wednesday, June 12, at 4 o'clock P.M. The president, Dr. L. A. Phillips in the chair. Dr. Chas. M. Fuller was elected secretary pro. tem. The treasurer, Dr. J. H. Sherman, reported the society to be in good financial standing, there being a surplus in the treasury.

The following physicians were elected to membership ; viz :

Geo. D. Bliss, M.D. and N. L. Damon, M.D., of Dorchester ; A. H. Powers, M.D. of Boston. S. L. Eaton, M.D., of Newton Highlands ; Fred. W. Elliot, M.D., of Boston Highlands. J. E. Luscomb, M.D. of Fitchburg ; M. W. Turner, M.D., of Brooklyn. Drs. Geo. B. Peck and H. A. Whitmarsh, delegates from the Rhode Island Homœopathic Society, were present. The papers presented before the society were the following, viz. "The Intra-uterine Spray in Diseases of the Endometrium," by Edwin M. Hale, M.D., of Chicago. Read by the secretary. "A Comparison of the Various Treatments of Wounds," by W. P. Defriez, M.D., "Some Obscure Clinical Cases," by D. B. Whittier, M.D., "Puerperal Septicæmia, by J. H. Moore, M.D., "Cases of Interest from One Quarter's Service in the Mass. Homœopathic Hospital," by A. Boothby, M.D., "A Complicated Case of Syphilis and Gonorrhœa," by W. H. Tobey, M.D. The discussion that followed the reading of the papers was freely taken part in by those present.

EDITOR'S TABLE.

As an adjunct to correct diagnosis the tampon is worthy of study. Many patients have been under treatment for years for stomach troubles, says Dr. Schultze, who have been declared sound in the genital organs by gynæcologists whom they have consulted, because palpation and the speculum gave nothing abnormal, and who, upon application of the diagnostic tampon, demonstrated purulent endometritis, and were freed from their difficulty by means of dilatation, methodical irrigation of the uterus, and the proper remedy.

The tampon consists of cotton, from which the fat has been removed, freely soaked in a 20 to 25 per cent. solution of tannin in glycerine, and firmly pressed in the vaginal vault, previously carefully cleaned, so that the mouth and vaginal portion of the cervix are completely covered. The glycerine in the tampon draws the water freely from the surrounding tissues, and permits the same to flow out, together with the water of the secretion. The formed constituents of the uterine secretion will only to a slight degree be floated over the place on which they come in contact with the tampon. If the tampon is removed after twenty-four or forty-eight hours, one finds on the same, in a wholly healthy uterus, corresponding to the place of the os uteri, only a small mass of cervical secretion, clear as glass. If the mucous membrane in a section above the mouth of the uterus is affected with catarrh, one finds, besides, on the tampon, pus which has come from the uterus during the same time. The tampon has attached itself so closely around the vaginal wall, that it takes off the most superficial epithelial layer of the vagina over its entire superficies.

* * *

Dr. Schultze has used the tampon in this manner for twelve years, and confirms the diagnostic value of the same. It concerns the diagnosis of a very great number of cases of endometritis, in which, so far, the usual diagnostic means fail, and whose diagnosis must be in proportion to the indications placed at the disposal of physicians.

* * *

A correspondence, extending over some months in the British Journals on laceration of the perinæum and the use of the forceps shows that the subject is one of widespread interest abroad. The questions that immediately present themselves are : (1) What are the conditions that dispose to and cause laceration of the perinæum from the labor apart from operative interference? (2) Are lacerations more, or less, frequent under operative treatment, especially the use of the forceps?

The first impulse is to seek a solution in statistics ; but ever so little reflection will prove that the key cannot be found in any figures we are likely to command. Individual experience is likely

to govern the action of most, and an expression of the individual experience of this journal's readers is solicited and will be gladly given place in its columns.

* * *

Gynæcology and obstetrics were rather poorly represented at the International Congress of Homœopathy, held in Paris, August 21, 22, and 23 of this year. According to *L' Art Medical* the only papers on these branches were represented by the following:

"Blenorrhagia in the Female; Diagnosis and Treatment," by E. F. Blake, M.D. London, Eng.; "Hydrastis canadensis in Cancer of the Breast and in the Glandular Engorgements of that Organ," by Dr. Imbert, Lyons, France; "Iritis and Irido-choroiditis in Uterine Affection," by Dr. D. Parenteau, of Paris; "Homœopathic Therapeutics of Pregnancy," by Miss H. Keatinge, New York; and "Homœopathic Therapeutics Applied to Diseases of Women," by Miss Isabelle Rankine of New York.

* * *

We may perhaps account for this paucity of papers by the fact that so few are disposed to undertake an ocean voyage and to lose four or six weeks of time just in the beginning of the busy season. However, what was lacking in quantity was partly made up in the excellent quality of the papers that were presented. But we hope, when a future congress is held, that there will be a more thorough organization of the bureaus of Gynæcology and Obstetrics and an individual appeal to every physician interested in the special branches to join in the interchange of opinions. Thus may we increase our knowledge.

* * *

Dr. Imbert in his paper on Hydrastis in cancer of the breast speaks highly of the remedy as retarding the evolution of the disease and causing in the great majority of cases rapid relief of the acute pains.

* * *

The experience of Dr. Parenteau, as given in the paper on iritis and irido-choroiditis in uterine disease, differs somewhat from what the majority of us have seen in this country; for we have

failed to find these diseases as frequent during the progress of female troubles as he indicates. The form of trouble which Dr. Parenteau meets most frequently is an affection of the vitreous humor of the eye, with or without inflammatory symptoms. The disease usually affects only one eye, causes rapid diminution of vision, and is characterized by presenting to ophthalmoscopic examination a grayish, uniform, and generalized dotted appearance of the fundus of the eye. The remedies which he finds succeed best are merc. cor., sulphur, and arsenic.

* *

Of the remaining papers those of Drs. Keating and Rankin are not accessible to us, and that on blenorrhagia in the female, marked by the well-known name of Dr. Edward Blake, of London, is too long for editorial comment, except to note the author's opinion that even in a slight degree blenorrhagia can be a cause of chronic leucorrhœa, of perimetritis, and of inflammation of the pelvic cellular tissue. With this the patient falls into a state of languor with a very significant pallor, the commencement of a *blenorrhagic cachexia*. There is often at the same time a violent and rebellious urticaria.

* *

In 1892 the World's Fair will probably be held in New York. Should not the American Institute meet that year in New York or vicinity, and invite representatives of homœopathy from all the civilized world.

* *

Dr. Gunther, of Montreux, France, reports success from the use of electricity in the vomiting of pregnancy. Five cases were cured. In none of these could be found pathological lesions of the uterus or its annexes. The mode of application of electricity in these cases was as follows: The anode, in the form of a sponge (insulated from the vaginal walls) was carried up to the cervix uteri. The cathode was placed on the vertebral column, between the eighth and twelfth dorsal vertebræ, and represented by a metal plate measuring ten centimeters by fifteen. The current strength was used at from two to three milliamperes, and in no case was it allowed to exceed five milliamperes. Each sitting

lasted seven to ten minutes, and generally after the fourth application the vomiting disappeared.

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Now, while it is not necessary to discredit the results obtained by Dr. Gunther, yet we must say that this procedure requires the utmost caution. On the one hand we believe that there are some cases that will be found amenable to the galvanic current, and our opinion is thus moulded by the wonderfully good results that have been obtained in relieving the reflex nausea and vomiting of various pelvic lesions. On the other hand such treatment applied to the gravid uterus must be surrounded by every precaution. We would advise, first of all, replacing the cathode of Dr. Gunther, the simple metal plate, by an electrode covered with chamois, with sponge, or with a thin sheet of absorbent cotton. Any of these materials, moistened and interposed between the skin of the back and the metal of the electrode, will lessen the amount of the electro-motor force requisite to produce a given current, and at once obviates the burning caused by the bare metal.

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We further say never attempt to use the galvanic battery on the uterus of a pregnant woman (or in any other case if exact results are desired) unless you possess a milliamperé meter, for this instrument is the only safe guide to the strength of the current that is being used. Tests with the tongue, with the temple, with the eyelid, can give comparative results as to the current strength; but such tests vary too much to be trusted in the case of which we speak.

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In experiments of this kind, for experiment it will be, and that one only to be tried after the vomiting of the pregnant woman fails to be relieved by the ordinary remedies, it is well to inquire a little into the idiosyncrasies of the woman with regard to electricity. In this direction we have found some marked differences with regard to the tolerance of galvanic currents, some complaining bitterly of a current which others again will scarcely feel.

Apropos of this subject, we were much surprised the other day in listening to a case related by a practitioner. We were told that in a certain case he had occasion to use the galvanic current ; one pole passed up into the cervix at least one inch and one-half, the other pole on the abdomen ; that, after several treatments, of ten minutes each, with a current of 20 to 30 milliamperes, according to the ammeter, the woman coolly informed him that she was much *disappointed*, as she had hoped an abortion would follow his treatment. She had not menstruated for two months, and had come for another trouble, intending to deceive him in hopes he would adopt some treatment that would get her out of her condition. Our friend was, of course, horror-stricken, as he had passed the sound into the uterus at least five times, on each occasion using the current mentioned. The case was carefully watched, but no bad symptoms arose, and it was with great satisfaction that he attended his patient during delivery at full term, about seven months later.

* *

While on the subject of galvanism, we will speak of an electrode lately brought into use with much satisfaction ; that is Dr. Martin's abdominal electrode. This consists of a nickle-plated concave plate, eight inches in diameter, covered with a membrane, and holds about one pint of fluid. It is filled by means of a nozzle on the upper surface. After contrasting this electrode with Apostoli's clay electrode, and with the gelosine electrode, we can recommend it as more cleanly than the former, and more easily prepared than the latter. The flexibility of the membrane permits a very even contact with the abdominal wall, and distributes a maximum of 250 milliamperes without producing an eschar.

* *

Dr. Grammatikati (*Vratsch*) of St. Petersburg has made a contribution to the study of the state of the ovaries after extirpation of the uterus, from which some useful conclusions may be drawn. The experimental studies of this author have been performed by examining the ovaries of rabbits from which the uterus had been removed. By this means he was able to decide that the operation did not effect the ovarian functions. The follicles arrived at

maturity, ruptured and formed yellow bodies as in the normal state. Besides this, Grammatikati was fortunate enough to have an opportunity to examine the organs of a female that had undergone a total hysterectomy for cancer of the uterus about four years before. He found, at the autopsy, the place of the uterus occupied by a cicatrix, the large ligaments adherent to the bladder, the Fallopian tubes transformed into serous cysts, the ovaries normal, except the left, which had a small cyst the size of a bean. All these organs were covered by a thick layer formed of false membranes. The ovaries, of which the dimensions were nearly normal, were separated from the other organs, hardened in alcohol and embedded in photoxyline in order to prepare sections. With the microscope, it was found that the ovaries possessed follicles in all stages of development. The largest resembled completely the Graafian follicles, when rupture is imminent, and at the border of these the vessels were abundant and engorged, while at other points the vessels were almost empty and the tissue appeared anæmic. Besides this, there were corpora lutea in all stages and some which were so recent in appearance that they could by no means be attributed to a period previous to the hysterectomy.

Reasoning from these microscopical appearances, it is impossible not to conclude that the ovaries remained active after the removal of the uterus, and that so long as these organs do not undergo retrogression subsequent to the hysterectomy they should be removed with the uterus. We should then adhere to the ordinary hysterectomy and condemn the extra-peritoneal operation proposed by Franck (*Arch. f. Gyn., t. xxx.*), for by this method the ovaries are necessarily left in place.

GYNECIC ETCHINGS.

—*Tilia Europea* will sometimes be found useful in puerperal metritis when there is an intense sore feeling about the uterus; it is also characterized in a gynæcopathia by marked bearing-down, with hot sweat which gives no relief.

—In fungous endometritis it is well to remember that careful inquiry will sometimes trace out an antecedent syphilitic history;

and even if this history be absent it is well to bear in mind that underlying the disease may be a condition of hereditary syphilis.

—*Inula* (elecampane) has been found like sepia to produce uterine pains and bearing down, also dragging in the genitals, backache, urging to stool and to micturition. These are important symptoms and ought to have clinical verification. The number of *proposed* remedies for diseases of women is increasing beyond our ability to cope with them, and we hope that some of our writers will join in the labor of weeding out the tares from the wheat.

—M. Fage remarks, in *La Gazette des sciences médical de Bordeaux*, that the retention of urine which may complicate the eruptive fevers appears not always in the grave cases, but also in the most benign cases. He cites, apropos of this, the case of a young girl who, attacked by a mild rubeola, had on the second day of the eruption a complete retention of urine which lasted during the three days. He found the same in a mild case of typhoid fever. This case had on the eighth day a retention of urine which lasted forty-eight hours.

—M. Ruth, of Muscatine (*Bulletin Médical*), in a study of the effects of opium on young children, has found that this remedy, even in very feeble doses, produced convulsions that sometimes were fatal. In these conditions he thinks that when one administers opium to a pregnant female the foetus will suffer from the harmful effects, and that these effects should be translated by convulsions. Of this the author cites a case: a pregnant woman, who had taken some doses of opium, noticed some time after the administration of the drug violent and almost unbearable movements of the child. To our old-school friends this should be a vigorous warning to expurge from their text-book that portion which advises opiates as a treatment for abortion.

—Prof. T. Annandale has operated successfully in a case of intussusception in a child three years of age. The child presented the usual symptoms of intussusception; pain, vomiting, passage of blood and mucus by rectum, and a sausage-shaped tumor in the left lumbar region, which was felt in the rectum, and could

be reduced by bougies and enemata. The author opened the abdomen by a central incision about two inches in length, and discovered a pear-shaped tumor, about four inches long, in the lumbar region. This tumor was laid hold of with the finger and drawn towards the wound, but in doing so it somewhat suddenly dispersed, and about eight inches of collapsed, wrinkled, and sodden-looking intestine presented, and it was quite evident that the comparatively gentle traction exercised upon the small intestine had relieved the invagination and taken away the cause of the obstruction. Immediately after the operation wind began to pass freely by the rectum, proving that the obstruction had been relieved, and from this date the patient's progress was excellent. The author emphasizes the importance of early operation in cases of acute intussusception, or other forms of acute intestinal obstruction, when other means have failed to relieve the condition after a careful trial of them.

—Prof. Ruggi is a late convert to simple boiled water for laparotomy. At the late Congress of Italian Surgeons the Professor presented a statistical account of 116 cases of laparotomy in which bichloride of mercury solution had been used, giving 107 cures and eight deaths. In two of the fatal cases he admitted that death was undoubtedly due to the use of the sublimate, the autopsy revealing a toxic degeneration of the hepatic and renal cells. The lesson which Ruggi has learned from this had decided him hereafter to use only boiled water, instead of the sublimate solution. In the discussion following this change of heart on the part of Professor Ruggi, Professor Bassini announced that he also had observed two deaths from sublimate poisoning, and that he now used salicylic acid instead.

—We believe, apropos of these cases of death from sublimate poisoning, that there is sufficient grounds for severe condemnation of the use of the bichloride of mercury as an antiseptic, and especially when used for irrigation. For, all irrigations of large wounds requires a considerable amount of solution, and the corrosive sublimate becomes almost entirely decomposed, leaving in the tissues, with which it comes in contact, not only a necrotic area of slight depth, but another noxious agent in the form of the

albuminate of mercury. If we must, then, pin our faith to an antiseptic, if *absolute asepticism*, without the use of drug solutions in which to wash our hands and instruments, is impossible, let us at least take a drug which at its maximum antiseptic action is incapable of producing the sad accidents that we can lay at the door of corrosive sublimate.

—Dr. A. Edington, Lecturer on Bacteriology, Edinburgh, says that we have such a drug in the new antiseptic, hydronaphthol. Its maximum antiseptic action lies between 1 in 2500 and 1 in 3000. This is less than the maximum of corrosive sublimate but, as hydronaphthol is non-poisonous, a saturated watery solution of 1 in 1000 may be freely made use of. Concerning its non-poisonous property Dr. E. says: Considered from the point of view as a germicide, it is seen that it is at least as powerful as corrosive sublimate for anthrax and more so for bacillus subtilis, when the latter even is being used under conditions most advantageous to it. I have given three grains in one day, and repeated it on three occasions successively to guinea-pigs without any effect and I have myself taken it without experiencing any result whatever. It is further reported that doses of fifteen grains have been given without any untoward symptoms whatever. Looked at in this way, the use of hydronaphthol is suggested to us as an internal antiseptic, and I have, indeed, made several experiments with it upon animals which, though encouraging in their results, do not warrant me in giving a definite expression of opinion. There can, however, be no doubt of the fact that in this agent we have an ideal antiseptic.

—Besides the various spontaneous terminations of extra-uterine pregnancy that are on record—mummification, foetal encystment, and rupture of the membranes with subsequent peritonitis—there is a curious case cited by Dr. Bengnies-Cobbeau (*Gazette franc. de méd. et de pharm*). This woman at first suffered from violent abdominal pain and believed herself pregnant, but was assured by her attending physician that she had an ovarian affection. However, she was convinced of her state of pregnancy, and at a time coinciding with the end of the ninth month was again taken with pains and called a physician. Labor lasted three days with no

result and the accoucheur beat a retreat with the words "*dropsy of the ovary*." The pains subsided at that time, but the details of symptoms are wanting for the next three years. At the end of this time there appeared on one buttock a large abscess from which emerged some fragments of a foetal skeleton. This abscess was followed by a second on the other buttock, by a third on the lower abdomen and by a fourth on the perinæum. The last abscess sac only closed when the last of the foetal remains was expelled. This consisted of a black porous scapula. Dr. Cobbeau states that in all ten years passed from the date of the pains of labor to the expulsion of the last of the foetal skeleton.

—Dr. Zayaitzky (*Gazette de Gynecologie*) is an enthusiast on the subject of shortening the round ligaments after the method of Alexander Slawiansky. Concerning a series of twelve cases which he has operated on he makes the following conclusions :

First. Alexander's operation presents no danger to life.

Second. The *technique* of the operation is easy but beginners study it first on the cadaver.

Third. From the good results obtained by the majority of those who have performed this operation, it merits application in the cases where it is indicated. More than this, in cases where success is possible, it does not derange the health nor impede the application of other processes, even if there is no success.

Fourth. Alexander's operation corrects posterior displacements of the uterus in a manner more durable, and more rapid than pessaries, massage, or electricity.

Fifth. In prolapsus uteri, complicated by perinæal rupture or by hypertrophy of the vaginal portion of the cervix, it is necessary to precede the operation by colpoperineorrhaphy or by amputation of the cervix.

Sixth. The method of Alexander Slawiansky is the best.

Seventh. The method of seeking the ligament by the internal inguinal orifice, with opening of all the canal should not be adopted.

Eighth. The method of Casati is rational : the ligament, in case of adherence, is retained there more firmly as it is sutured in the non-opened canal, and by a great number of sutures as in the method of Alexander.

Ninth. It is not necessary to keep the patient, after the operation, in the dorsal decubitus with the thighs flexed for three weeks (Alexander). One week of dorsal decubitus, with the thighs extended, is sufficient.

Tenth. The pessary is useless in the post-operative period, and its introduction is not without danger to the results of the operation.

Eleventh. It is useful to prescribe a pessary, after getting up, to be worn during a month ; this, to favor the involution and the strengthening of the ligaments.

Twelfth. Pregnancy, following after the shortening of the ligaments, takes a normal course.

Thirteenth. Ventro-fixation of the uterus by laparotomy is, undoubtedly, a dangerous operation, exploratory laparotomy likewise ; it can not be admitted as an independent operation by the side of Alexander's operation, except in adhesions of the retro-flexed uterus where they cannot be destroyed in any other way. Ventro-fixation is only indicated in grave cases.

GOLDEN GRAINS.

—*Ambra grisea* is supposed to be characterized by a leucorrhœa consisting principally of "bluish or bluish-gray mucus," but if you turn to your repertory and prescribe on this one symptom alone you will certainly fail.

—Gynæcological practice requires just as careful consideration of *pathological conditions* as it does of *symptomatic indications*, and unless we look carefully to the former we will certainly be misled as to the relative value of the latter.

—We would therefore never expect to relieve a woman of a "bluish leucorrhœa," unless we found included in the totality of symptoms an engorged uterus and the pelvic tissues relaxed and weakened. At the same time these pathological conditions furnish us with the following symptomatic indications. Menses too early, too profuse, and accompanied by nose bleed. Discharge of blood between periods. Extra efforts, as of straining at stool, or any excitement, brings on a metrorrhagia characterized by slow oozing.

Add to these symptoms, bluish leucorrhœa, in lumps, and constipation in a thin, scrawny, nervous woman and the ambra grisea picture is complete.

—Fehling (*Journal de Med. de Paris*) after making a series of experiments as to the effects of drugs upon infants when administered to the nursing mother, found that salads and acids have no injurious effect upon the child. Most drugs require relatively large doses before any effect on the child's system could be perceived. Salicylate of sodium required forty-five grains per diem before producing dangerous symptoms in the infant. The iodide of potassium in doses as small as three grains daily would be safe. Iodoform enters the system of the babe, through the nurse, more readily than when given directly. Iodine was found in a child's urine, nursed by a woman who had an iodoform dressing on a wound. Mercurial salts have but little effect upon the child, and twenty-five drops of tincture of opium and three-tenths grain of morphine could be safely given to a nursing mother. Atropine in small doses affects the child quickly.

—Not long ago a paragraph in the *Medical Counselor* brought forward abnormal positions of the uterus as a cause of sciatica. To-day, while studying ammonium muriaticum, we are reminded of a case interesting in its relations, both to that paragraph and to this drug. A young woman came to us for treatment for sciatica. She related a history of prolapsus uteri for which she was treated in a New York hospital. While under this treatment she asserted that they used a very large Sims' speculum which hurt her "dreadfully" while the nurse was retracting the perinæum (the young woman was unmarried and of respectable family. Of what avail the speculum here?) that she became distrustful of the hospital surgeons, and removed herself from their care, and that from that time to the time she came to consult us she had suffered from occasional paroxysms of sciatica of the left side.

—Digital examination revealed a prolapsus uteri and a slight degree of retroversion. During the exploration pressure was made with the finger in the direction of the left great sacro-sciatic foramen with the result that the patient complained of soreness in that position and a sharp pain darting down the out-

side of the left thigh. The knee-chest position and retraction of the perinæum sufficed for the reposition of the misplaced organ, and relieved the sciatica at once. The patient was directed to use the knee-chest position every night and ammonium muriaticum 6x was prescribed. After six weeks of treatment in this manner, the patient reported that she had felt none of the pain in the left limb for three weeks, nor had she felt any of the symptoms of prolapsus, and examination showed the organ in place. Accordingly she was discharged.

— Why ammonium muriaticum? The patient complained that in walking there came occasionally a sensation as if the nerve in the left hip was too short and she suddenly stretched it in stepping. The pain of her sciatica was also a dull pain, as if the nerve was drawn too tight. This pain was worse when sitting, somewhat relieved when lying down (quite corresponding to the idea that the prolapsed uterus pressed on the nerve). All of these symptoms presented such a perfect similarity to those of ammonium mur. that we had no hesitation in predicting from its use a perfect cure, both of the prolapsus uteri and of the sciatica.

— We are unable to find other verifications of ammonium mur. in prolapsus uteri, but Farrington states that on the female pelvic organs this drug acts more powerfully than does ammonium carb. From the great variety of symptoms referred to the inguinal and hypogastric regions, he suggests its use in uterine and ovarian diseases. "For instance, the patient complains of tensive pain in one or the other groin. Sometimes this symptom is described as a feeling as if she had sprained herself. There are stitches, cutting, and soreness, or what is more characteristic than all, a strained feeling in the groin which forces the patient to walk bent. That is an indication which leads to ammonium mur. in the treatment of deviations of the uterus and also in ovarian diseases. You will find in almost all these cases the characteristic muriate stool, crumbling as it passes the anus. We have, too, a characteristic leucorrhœa attending the symptoms, a brown and lumpy, or else clear and albuminous leucorrhœa which follows every urination."

—Dr. P. J. Murphy (*Obstetric Gazette*) in reviewing the very favorable statistics of Cæsarean section in late years, finds great

reason therein for entirely discarding craniotomy in all cases and substituting the delivery of the foetus by an abdominal section. By those who favor craniotomy it has been justly urged that we should not place the uncertain life of the child on a par with the valuable life of the mother, but no thinking man can refuse to give some value to the life of the unborn child. Just how great this relative value is to be, is a point difficult to decide ; but, as at least one-third of all children born reach maturity, including those reared in cities under the most unfavorable circumstances, we will certainly do injustice to the children if we give their lives less than one-third the value we attach to the life of the mother. And when we find the results of craniotomy and Cæsarean section so nearly balanced, when we consider the welfare of the mother alone, surely a relative valuation of one-third or even one-tenth to the lives of the children must turn the scale in favor of the Cæsarean operation and make it the operation of election where it is possible to be done with hope of success.

When medical men in general come to recognize the superiority of the Cæsarean operation we may hope to reach results that are better than those of the present day, and for the following reasons :

First. The necessity of the operation being recognized, it will oftener be done at the proper time—before rude efforts have been made to deliver in other ways and before the woman is exhausted by other procedures. Proper preparations will be made and skillful operators procured.

Second. The operation, though much improved of late, so much as to render it, even in its present state, preferable to craniotomy, is still imperfect and there is no doubt that its dangers will be greatly lessened.

On this point Dr. R. P. Harris (*Br. Med. Jour.*) has collated a series of interesting statistics relating to the Porro Cæsarean operation. The total available record (1876-1888) amount to two hundred and fifty operations in fifteen countries.

It is a noteworthy fact that while there were twenty-nine deaths in the first fifty cases, in the last fifty there were but nine ; eighteen operations have been reported since January 11, 1885, with sixteen deaths and one suicide in an improving patient. The last

fourteen operations of 1888 saved all of the women and children but one each. It is expected that this record will be augmented by researches still in progress the result of which will be published when completed.

The operations are credited as follows :

<i>Countries.</i>	<i>Cases.</i>	<i>Women Recovered.</i>
Italy.....	85	43
Austria.....	61	42
Germany.....	41	21
France.....	17	6
England.....	12	5
Russia.....	7	5
United States.....	7	2
Belgium.....	5	3
Switzerland.....	4	3
Scotland.....	4	0
Holland.....	2	1
Australia... ..	2	2
Spain.....	1	0
Mexico.....	1	0
Japan.....	1	1

Breisky of Vienna and his two assistants have together operated eleven times with no death of mother or child. Porro of Milan (formerly of Pavia) have done six operations with only one death. The lowest mortality has been found in elective operations and in hospitals either before the full period of gestation was complete or immediately after the onset of labor. Dr. Harris says that his researches have not led him to hope for a recovery of 95 per cent. as thought possible by Mr. Tait, but they have given encouragement to believe in a possibility of 80 to 85 per cent. in very careful hands. As the Saenger Cæsarean operation has saved sixty-six out of seventy-eight women in Germany, he sees no reason why the Porro method under the same degree of care cannot accomplish like results.

—In the feeling as if sprained in the groin ammonium mur. has counterparts in several other remedies, but somewhat differently expressed. In the arnica patient it is a "bruised sore feeling in the uterine region, which prevents her from walking erect."

Apis also approaches ammonium mur. in its bruised, sore, or strained feeling in the ovarian region, but there is, besides this, the characteristic burning or stinging pains always present.

BOOK REVIEWS.

TRAVAUX D' OBSTÉTRIQUE du Docteur A. Auvard. Tome Troisième. Lecrosnier et Babe, Editeurs, Paris, 1889. [Obstetrical Works of Dr. A. Auvard.]

At the present estimate of appearances Dr. Auvard is in a fair way to give us a new Cyclopædia of Obstetrics ; he apparently considers it a labor of love to work out solutions to those obstetrical questions that are surrounded by doubt, and as these are still numerous there is yet a wide field before him. The third volume is of equal value with those already reviewed. The author contributes to the solution of, "The Extraction of the Fœtal Head," "Presentations in General, and in Particular of the Forehead and of the Abdomen," "Lateral Obliquity of the Gravid Uterus," "Sudden Puerperal Death," and "The Diagnosis of the Date of Accouchement."

All of these questions are of great importance, and the data that Auvard furnishes are of the utmost value. We are especially interested in his conclusions on "Lateral Obliquity of the Gravid Uterus," and reproduce them as one of the best comments on the value of the work :

"The deviation of the uterus during pregnancy, designated by authors generally under the name of lateral obliquity, is not due to a true inclination of the organ during gestation, but to an apparent inclination.

"It is not, in fact, an inclination of the uterus toward the right side or toward the left side, which is the cause of this lateral obliquity, but a want of equality and of parallelism, in the development of the two halves of the organ.

"When there is a true inclination, it is secondary to this apparent inclination ; it is due to the fact that the uterus is drawn as a whole toward the side most developed.

"The form of the gravid uterus plays an important part in the situation of the fœtus." Upon the remainder of the subjects which are considered Auvard has equally positive conclusions, and as they are based upon a larger number of carefully cited cases they carry great weight in opposition even to some of our most prominent authorities.

ORIGINAL TRANSLATIONS.

The Editor is assisted in this department by Dr. S. Lillenthal, San Francisco, Dr. H. H. Crippen, San Diego, Cal., and Drs. Pick and Pritchard, Boston.

PNEUMONIA AFTER LAPAROTOMIES IN CONSEQUENCE, OF DECOMPOSITION OF CHLOROFORM BY GAS LIGHT.—Prof. Zweifel of Leipzig gives a hint that laparotomies, if possible, ought not to be made when the patient suffers from a bronchial catarrh. Experience teaches that, where this operation was performed, they feel severe pains at the sutures during the cough from the tugging at the threads or wires. On account of the pain expectoration is suppressed, and respiration superficial. The secretions, which are thus held back, stagnate and increase the secretion and inflammation of the mucosa, and a harmless, bronchial catarrh changes into a catarrhal pneumonia, which may become fatal. Let us try to remove at first the bronchial affection, before we think on the operation, or still it may happen that after the total cessation of the cough a grave bronchitis and catarrhal pneumonia may set in after such operation, and even it may happen where the patient after a thorough examination failed to reveal the least symptom of a pulmonary affection. Once this happened after a Cæsarean operation, performed at night by gas-light, which produced such a vapor in the room that everybody felt a scratching sensation in the throat and some cough. It is a well-known fact, that off and on, where much chloroform is used at night, noxious vapors arise from the decomposition of the chloroform in petroleum or gas-lamps, which are injurious to the respiratory organs and cause cough, and might be partly prevented by satisfactory ventilation and using it in moderation. If possible, electric lights ought to be provided in every operating room in order to obviate this danger. As chloroform-narcosis, artificial light, and inhibited expectoration caused this dangerous state, Zweifel changed to ether-narcosis; but this is a very inflammable substance, a fact which the surgeon must never forget. Some patients are hard to bring under its influence and he uses now the chloroform-ether—alcohol mixture (100: 30: 30) and the patient is brought under its influence in another room, and when brought into the operat-

ing room, only small quantities of ether are necessary during the operation to keep up narcosis.—B. K. W., 15, '89.

ENDOMETRITIS TUBERCULOSA CHRONICA.—This is an affection primarily characterized by tubercular degeneration of the endometrium. We say primarily, but the uterine parenchyma and the perimetric region can be equally invaded.

Form.—It may assume two forms, the first, primary, the second, secondary, to tubercular lesions of other organs. We are here only occupied by the first form.

Etiology.—Two orders of causes, predisposing and determining. The predisposing causes are, in general: physiological pain, heredity, chagrin, etc.; local predisposing causes: lacerations of the cervix, repeated inflammations of this region.

With regard to determining causes, it is often difficult, in a given case, to discover them. It is rational to believe in the influence of soiled linen, perhaps even instruments badly cleaned. But that which is especially necessary to admit is the etiological importance of sexual relationships with a subject affected by general tuberculosis, and the more reason if affected by genital tuberculosis.

We have seen that which is again a proof by analogy, in the third category, tuberculous endometritis determine lesions of the same nature in the genital organs of the male.

We have also seen the injection of bacilli in the vagina of rabbits determine disease which interests us. It is then very certain that tubercular endometritis is most often, if not always, the result of a local infection.

Is tubercular endometritis frequent? Without being able to demonstrate it, we have much reason to believe that it is, that it exists in many cases unrecognized.

Pathological Anatomy.—In one case a histological analysis has been made and the fungosities of Koch's bacilli found.

In two other cases the inoculation of animals has given positive results.

Symptomatology.—We do not speak here of the pelvic peritonitis and the adeno-phlegmon which have more particularly fixed the attention of other observers. Primarily, these should be rare, or manifested in a form of acute local tuberculosis which we have

not been able to observe. Consecutive to tubercular endometritis they do not present any peculiarity as to their nature and do not then logically enter into this study.

With regard to the symptomatology of tubercular endometritis it has been clearly evolved, we think, from our observations.

Without any appreciable cause, the woman is attacked by leucorrhœa, acute pain in the abdomen, micturition, and constipation.

Sterility is the rule while the specific inflammation of the endometrium lasts. Touch indicates nothing at the beginning. Only much later when the lesion is extended, one can feel by touch combined with abdominal palpation, that the uterus is double in volume, and more or less immobile in the inflammatory adhesions of the broad ligaments.

The inspection by the speculum shows a reddened cervix, sometimes ulcerated, the orifice irritated and giving issue to a sanious discharge.

The uterine sound (we prefer a simple bougie of small size) permits of ascertaining in the beginning that the cavity is narrowed, the instrument passing with some grating, and later it shows that the parenchyma is affected, the cavity becoming more spacious in depth as well as laterally.

Finally, by examination of a bit of mucous membrane one can recognize histologically the characters of tuberculosis.

If from the local symptoms we pass to the analysis of the general state, we see that, in the beginning, the patients are more enfeebled than in simple endometritis. There is emaciation, fever, sweat, etc., as in all the local manifestations of tuberculosis.

Diagnosis.—The histological analysis of the fungosities of the endometrium permit of establishing the diagnosis in a positive manner. But in default of this the diagnosis can be made on the following symptoms :

The disease did not begin after a parturition nor after a blenorragia ; often the patient has not had children (five times out of nine in our observations). It is observed in an enfeebled woman. Sometimes likewise—this is the rule after a certain length of time—the lungs present the tubercular lesions. The

absence of colic at the menstrual period, the absence of hæmorrhage (Darenberg has shown that amenorrhœa is more often present), separate it from fibrous infiltration, from the beginning of a fibroid.

We do not speak of the differential diagnosis of tubercular metritis and of versions and flexions of the uterus. These affections are not ordinarily distinct diseases but accompany simple metritis.

Prognosis.—Consecutively, tubercular endometritis is very grave, not by itself, but on account of the general trouble.

Primarily, it is generally benign, if it be diagnosed early and treated with care.

Treatment.—First, it is necessary to put the patient on creosote.

Excellent against tuberculosis, whatever may be its manifestation, we think this remedy is most active against its genital localizations.

We advise locally simply two or three dilatations with a tent (antiseptically prepared by soaking for some hours in etherized iodoform); then after some days interval we apply successively fifteen bougies of iodoform.

Finally we advise the woman in the interest of her husband to abstain from all sexual relations until we pronounce her cured.—
DR. JOUIN, *Gazette de Gynécologie*.

MISCELLANEOUS.

—The annual class for complete course of didactic and clinical instructions in Orificial surgery will be held in Chicago, by Dr. E. H. Pratt during the week beginning Sept. 2nd.

—"Going upstairs" is asserted by a writer in the *Omaha Clinic* as a cause for breech presentations. He found they occurred in his practice only while a resident of a large city, and not in the country.

Dr. S. P. BURDICK says: that puerpural convulsions are due to a hydræmic condition of the blood, therefore the patient should be quieted with an anæsthetic, as every effort of contraction forces the hydrated blood into the brain and we have serous apoplexy.

In cases of lacerated perinæum he operates immediately and uses iron-dyed silk and not wire.

THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

A. L. CHATTERTON, EDITOR AND PUBLISHER.

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2. For the convenience of subscribers, this journal will not be discontinued until so ordered.

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VOL. XI.

SHOULDER PRESENTATIONS.

BY

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Fortunately for prospective mothers, but in a measure unfortunately for accoucheurs, shoulder and other abnormal presentations of the fœtus are not sufficiently numerous to make their character and treatment, as compared with those of normal labor, objects of general familiarity. Their consideration from time to time, even though nothing new be forthcoming, becomes, therefore, of value, for their rarity in the practice of the general practitioner, and sometimes of the obstetrician, is apt to make him lose sight of many points of importance in their management.

This article is a partial *résumé*, intended to refresh the memory and quicken the interest in the treatment of abnormal presentations.

When it is considered that in 290 cases shoulder presentation occurred once (Churchill), and that out of 235 cases one in nine of the mothers and half the children were lost,

we have sufficient reason for keeping alive our knowledge upon the subject. The above ratio of mortality is probably less than obtains the country over, it being the result of the application of the best skill. Carelessness, procrastination, and even ignorance, are undoubtedly productive of a larger death-rate, if facts were known, which makes our reason for the present writing all the more cogent.

The conformity and axial measurements of the female pelvis hold such a relationship with the foetus and its safe delivery as to make natural the division of foetal presentations into the two of coincident foetal and maternal pelvic-uterine axes, and non-coincident foetal and pelvic-uterine axes. The first is divisible into cephalic (*a*, head flexed; *b*, head extended), and pelvic (*a*, breech; *b*, foot); the latter into the right shoulder and left shoulder.

Abnormalities in the delivery of coincident foetal and maternal pelvic-uterine axes, have little or no reference to these axes, of course, but with respect to non-coincident diameters, to deformed pelves, etc.,—in other words to the position of the child, or to the character of the maternal outlet.

As to non-coincident foetal and maternal axes, the dystocia is dependent upon non-conformity of the foetal axis with the maternal axis; that is to say: the two axes, instead of being the resultant of the foetal and maternal forces, are at angles with each other, and labor is therefore arrested.

From the fact that every successful labor must have been accomplished along the central axial line of the maternal outlet, it is clear that these angular positions must be corrected ere this can be possible.

As a prelude, perhaps somewhat long, to the discussion of the treatment of shoulder presentations, it will be well to recall certain facts concerning them.

Shoulder presentations include those of the hand and elbow, but these are mere modifications of the former. They include, likewise, all the so-called transverse or trunk

presentations, as they resolve themselves finally into presentations of the shoulder.

Shoulder presentations are of two forms, each of which is in turn capable of division :

PRESENTATION.	POSITION.
1. Right Lateral Plane, Right Shoulder.	{ 1. Dorso-Posterior (head to the right iliac). 2. Dorso-Anterior (head to the left iliac).
2. Left Lateral Plane, Left Shoulder.	{ 1. Dorso-Posterior (head to the left iliac). 2. Dorso-Anterior (head to the right iliac).

This classification gives equally as clear, if not a clearer, comprehension of shoulder presentations as any given in the works. Some authors prefer the term trunk presentation, others transverse presentation, making shoulder presentations a division, *i.e.*, a position; but inasmuch as it is one or other of the shoulders which finally engage in the superior strait, the value of the term here used—shoulder presentation—is apparent. Moreover, when we come to treatment, a clearer understanding of existing conditions is had by bearing in mind the various relationships of foetal and maternal parts suggested by the above classification.

Frequency of Shoulder Presentations.—Depaul gives 189 out of 16,233 cases of labor; P. Dubois, 13 out of 2022; Puiard, 806 out of 100,000; Churchill gives 1 in 260 cases; Cœlius, basing the rate on 16,659 cases of labor, gives 1 to 555. My own ratio is two in 500. The rate is of course a variable quantity, as I have met physicians of very large obstetrical practice who have never had a case of shoulder presentation. We can safely accept Churchill's rate as that of the average.

Probably dorso-anterior positions are more frequent than dorso-posterior positions. The *Causes* of shoulder presenta-

tions are numerous, but cannot always be satisfactorily determined. They are such, however, as have to do with the interfering with the harmonious action existing (between the foetal and maternal forces) in normal labor. In other words, there is a disturbance of the normal correlation of the foetal and uterine long axes. Contributing to this result are such factors as force from without, of the nature of falls, blows, constriction by corsets, etc.; laxity of the abdominal walls, most to be expected in multiparæ, allowing the uterus to fall forward (Rinard); faulty conformation or shape of the uterine cavity, particularly a relative increase in its transverse diameter (Dauyou and Wigaud); immature foetus, miscarriage, excess of amniotic fluid, malformation of the foetus, attachment of the placenta low down in the uterus, narrow and deformed pelvis, and twin pregnancy. These furnish a variety of probable causes, any one of which is apt to be patent, though in my opinion those causes operating from without the pelvis are mostly responsible for shoulder presentations.

This furnishes a hint to the practitioners into whose care there comes a pregnant woman who has met with an accident likely to cause foetal displacement. Careful examination should be made for this malcondition, and the trouble rectified or carefully watched.

Diagnosis.—One of the many strict injunctions given by the accoucheur to the pregnant woman should be to inform him of the first intimation she has of setting-in of labor. She may sometimes needlessly summon him to her, and entail upon him a useless visit by reason of a "false alarm"; but by her timely warning she may save herself and her forthcoming child from disaster, and her accoucheur measureless trouble. I make it very plain at each one of my "engagements," to have the prospective mother realize the necessity for early notifying me of her pains, and that an examination made at the very outset of labor may give me information of the greatest value, and enable me to ren-

der her a service not perhaps possible later. Than in this, there is no presentation in which it is more essential that this injunction be obeyed. An unfortunate sense of security takes hold of many women, which united with a desire to keep the accoucheur as long as possible from her bedside, too frequently causes him to arrive after the moment when appropriate manipulation would have converted a harmful into a harmless condition, or one at least less so.

In every case, therefore, the accoucheur should be early at the scene. An examination should be made as quickly as possible, not simply to determine whether labor is in progress, but as to the presentation and position. The fact that several hundred successive labors have been those of the vertex, and not one a presentation by any of the other foetal parts, makes the average physician careless, and he rests confident in his good fortune not to have a break in this record. He should employ every means at command for the determination of the presentation, and should not leave the bedside until he is at least reasonably certain of the diagnosis. Vertex presentations are simple in their determination; breech presentations may without harm be at first confounded for those of the vertex; but it is *essential that shoulder presentations should be recognized at the earliest possible moment.*

Ramsbotham very wisely uses the words *suspicious symptoms* in referring to the early examination of probable cases of shoulder presentations, for it will happen that our diagnosis is a conjecture and not a positive assurance. But in most instances the existence of a shoulder presentation will manifest itself to the skilled accoucheur at his first examination after labor has set in, and sometimes before.

The finger ("with the eye on the end"—Penrose) of the examiner will find an absence, within the os, or through the uterine walls, of the usual ball-like body characteristic of vertex and breech presentations. Or it may find that instead of the bag of waters presenting in the usual manner, it pro-

trudes finger- or pouch-like through the opening os ; or again it may fail to find, though labor pains have actually begun, and are perhaps energetic, that any part of the foetus presents at the uterine opening. These conditions should make us *suspicious*. Another suspicious symptom is the cessation of pains for several hours following the rupture of the membranes (Ramsbotham). This, however, is not to be altogether relied on, as I have had it to occur when the vertex was presenting, though high up.

Having had our suspicions aroused, the examination should be pursued until satisfied (if possible) as to the character of the presentation, and of the position. If the membranes are not ruptured, the examination should be made *during the intervals between the pains*. It is essential that the membranes remain intact until we are satisfied that the presentation is normal, or until an abnormal presentation is corrected.

The method of examination is two-fold: First, by the finger within the os, or by palpation through the uterine wall, *per vaginam*. Second, by palpation externally.

1. Examination *per vaginam*.—When either *hand* has descended through the os, the bag of waters having broken, no likelihood exists of any difficulty occurring as to diagnosis, if the relative characteristics of foot and hand are borne in mind. The hand being felt, the existence of a shoulder presentation is, of course, undoubted. A comparison of the presenting hand with what is the normal relation of hand to body, will quickly give us to know whether it is the right or left hand, and whether the position is one of the four possible positions of shoulder presentations. Playfair gives this simple rule for determining the position where the hand presents: Provided we are sure the hand is in a state of supination, the back of the hand points to the back of the child, the palm to its abdomen, the thumb to the head, and the little finger to the feet.

The *elbow* may present. The condyles, with the olecra-

non midway, will enable us to diagnose between the elbow and the foot. Sometimes difficulty will be encountered in distinguishing the elbow from the knee. The difference between the patella of the latter and the olecranon processes of the former will be on the points of differentiation. The position of the fœtus is then determined by the direction of the elbow, which is always toward the foot.

The *shoulder* itself may present. It has been mistaken by hasty, careless, and ignorant examiners for the head. I have met with an instance of this kind, in consultation with a fellow-practitioner against whom could be brought the charge of carelessness, alone. The shoulder is round and smooth, and may likewise be confounded for the breech. The fontanelles and the larger size of the head, and the arms, organs of generation, etc., of the breech, will furnish the necessary landmarks as between the head and breech and their absence. The shoulder has its prominent acromion, the spine of the scapula behind, the clavicle and the ribs, and the axillary space, with which we can diagnose it. The axillary space is the most important of these.

The shoulder may be high up and beyond the reach of the finger. In such a case the ribs, the scapula, and the spine afford diagnostic points of great value.

What has already been said is presumptive of the rupture of the membranes. If intact, diagnosis *per vaginam* is not easy, and frequently impossible. We are capable of learning by this means perhaps no more than that the fœtus is high up. The part presented may be the face or the breech. *The fact that the presenting part is high* is not proof of a shoulder presentation, is a point always to be kept in mind. Under the circumstance of an inability to reach the presenting part by the finger, *per os uteri*, or of a fear that a prolonged examination will rupture the membranes, the finger should be withdrawn, and attention paid to the abdomen by palpation. Nothing very certain can be ascer-

tained by auscultation. All efforts should be directed to palpation, which alone is convincing.

Owing to the obliquity of the foetus in shoulder presentations, there will be a greater fullness at the sides of the abdomen than at the top, as is usual with normal presentations.

If in one iliac fossa palpation shows the presence of a large and movable (*i.e.*, movable before labor has actually set in, immovable if labor is going on) tumor-like prominence, and then in the other fossa another prominence not so large nor so movable, we can diagnose the former as the head and the latter as the breech. This examination is often difficult when the abdominal walls are rigid or thick. The foetal body should, if possible, be carefully outlined so as to confirm the position of the head. Having determined that a shoulder presents, what is the position? This is not so readily arrived at as is the former. By palpating the foetal body from the head to the breech, or *vice versa*, we can sometimes outline the position of the back. Then given the position of the head and breech and the contour of the back of the foetus, we can fix upon the position of the shoulder. We are now in condition to consider the treatment of shoulder presentations, for whilst it will happen that spontaneous version or spontaneous evolution of the foetus, in these positions takes place, this occurrence forms a very rare exception to the general rule. The accoucheur must, therefore, be ready to place in normal relationship with each other the now abnormally related foetus and maternal pelvis. If certain of his diagnosis, he should lose no time by anticipating spontaneous version or evolution. If either of these is taking place, it of course would be folly to interfere; but if not, every effort should be made to treat the case; for if version or evolution should not take place as anticipated, the life of both mother and child is jeopardized, and even if delivery seems possible by the natural powers, it is really a question of importance whether we should not interfere.

In the treatment of shoulder presentations it is possible to do one of three things.

1. Introduce the hand within the uterus, force away the presenting shoulder, grasp the head and bring it to the inferior strait,—a procedure not always possible, always difficult, almost certainly dangerous to the mother, but safest, if it can be effected, for the child.

2. By external or internal manipulation, or both, to procure version, bringing either

- a. The breech into the pelvic rim, an operation somewhat difficult, but reasonably safe for both mother and child ; or

- b. The feet into the pelvic rim, which operation is the safest for both foetus and mother, and the easiest of accomplishment.

Which of these methods is to be resorted to is not a mere matter of election on the part of the accoucheur, but he must be guided by the indications. If uterine contractions, natural or ergotic, have not set in forcibly, the membranes have not yet ruptured, and we are reasonably sure that the presenting part has not wedged itself firmly, disengagement of the shoulder and engagement in the os of the head or breech by external manipulation can be attempted with some hope of success. But caution is necessary not to prolong attempts of this kind, for the greater the delay the less the ease of treatment.

Manipulation within the uterus is helpful to external manipulation, and sometimes is alone effective. In endeavoring to lift up the shoulders in order to engage the head, care must be exercised not to rupture the uterus by the use of too much force. By far the most satisfactory operation is that of getting the feet to present. The greater number of practitioners spend very little time in a decision as to what to do, but immediately proceed to get the feet down. This routine treatment is not always wise. However, there is this important fact to consider: Turning

decapitation is impossible, by reason of the neck being out of reach.

In the absence of these instruments, a simple strong cord or wire can be placed around the neck by means of a catheter and maintained so by its stilet traction and a sawing motion soon separating the vertebræ. This is best done through a speculum. The use of the scissors may be necessary to finish the operation. The *écraseur* has been used with success, and the scissors alone have proved all-sufficient in the hands of some operators.

I can conceive of no necessity for amputating an arm prior to embryotomy. Cæsarean section, or uterine amputation, can be resorted to, and should they be done while the child is yet living, the chances are greatly in favor of its continued life, and about the same in favor of the mother. It might be well to consider whether the mother had better not run the gauntlet of a Cæsarean section in which her chances of life, under modern antiseptic surgery, are nine in ten, to the almost certain death of her child by version, and its certain death, of course, by embryotomy. For shoulder presentations Cæsarean operation has been performed in the United States twelve times, with eight recoveries (Harris).

In a contracted or greatly malformed maternal pelvis, Cæsarean section may be a necessity.

THE MANAGEMENT OF LABOR.

BY

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To offer anything new with regard to the conduct of labor is hardly to be thought of, the subject has been so frequently and ably dealt with by writers in this department.

But there are some points the importance of which needs

to be, to say the least, occasionally suggested, since the comfort and sometimes the safety of the patient may depend upon what some accoucheurs consider unimportant minutiae. But even in our art, which would not perhaps be reckoned among the fine arts, "Trifles make perfection, and perfection is no trifle."

When the first stage of labor is unduly prolonged, and there are worrying pains, nervous irritability, and impatience, there is nothing better to secure comparative rest, tolerance of pain, and courage to go on with the work, than to keep the patient a half-hour or even more in a warm bath. The resisting tissues are relaxed, the circulation to some extent equalized, and the nervous system quieted; so that the after progress is usually more regular and rapid than otherwise; there is also less danger of irregular uterine action, hemorrhage, or other accident. Good effects are undoubtedly obtained in such cases by hot douches, sedatives, and other measures, but in my experience nothing else has approached in efficacy the protracted warm bath.

In the second stage uterine inertia is a common and annoying complication, and many are the expedients that have been devised to combat it; such as giving various stimulants, hot nourishing drinks, friction, and kneading of the abdomen, electricity, hot and cold applications, the indicated remedy, and many other things. All these sometimes fail; in such an event, if the labor be not too far advanced, let the patient arise from bed, and move gently about her chamber, carefully watched and supported by an attendant. During the pains, which are pretty sure to come on soon after the erect position is assumed, let her lean against some firm support,—the foot of the bed for example,—upheld in a half-sitting posture by an assistant upon each side. In this way much is often accomplished by a few pains, the force of gravity coming to the aid of the aroused uterine contractions, and after the return to bed

the impetus gained is often sufficient to bring the labor to a speedy termination.

That the use of ergot in such cases is unsafe and should be avoided is the opinion of many eminent accoucheurs of to-day. Dr. Pajot goes so far as to say that it should *never* be employed so long as anything solid remains in the uterus. Some years ago a case illustrating the wisdom of this opinion came under my observation. A woman in labor had received ergot to hasten the third stage; tetanic contractions were set up and the placenta imprisoned in the uterus. All known means were persisted in for its removal for days, but to no avail, and the patient died of septicæmia ten days after parturition.

In case of hydramnios it is well to puncture the membranes before complete dilatation of the os, in order to forestall the spontaneous rupture, as with the sudden gust of fluid the cord might be brought down or an arm displaced in a manner to give trouble later on. The puncture should be as small as possible to be effectual, and may be made slightly within the cervical canal behind the symphysis pubis, and in the interval between pains. In this way the waters pass gradually, and the abnormally distended organ has time to retract upon its diminished contents, thereby limiting the tendency to hemorrhage, which generally exists in these cases.

Every effort should be made during and after the third stage to encourage the retractility and arouse contractions of the uterus, and every preparation made to combat a hemorrhage, which may occur in spite of all precautions to prevent it. Indeed it is my rule to prepare for a hemorrhage in every case, no matter how simple and safe it may promise to be.

When everything has gone well during labor and immediately afterwards, a busy practitioner is sometimes tempted to leave his patient, without waiting the usual time or giving the ordinary attention to the condition of the uterus, feel-

ing sure that all is right, and trusting to the wisdom and devotion of the nurse. In most cases he is safe in doing so, but exceptionally there follows danger to his patient and mortification to himself.

An incident in which an accoucheur of some eminence in a large city took no enviable part will illustrate this point :

After a somewhat prolonged, though quite normal, labor, Dr. G. delivered his patient of a fine boy, gave her, himself, a vaginal douche, as was his custom in such cases, but, as he was pressed for time, left without a final exploration of the abdomen, being sure that all was well, and well satisfied with his share in the event.

Shortly after his departure the patient summoned the nurse hastily to her bedside, saying that the pains had returned with great violence.

The nurse, to her amazement, found another child on the point of being born.

One can imagine with what sort of satisfaction Dr. G. regarded the twins on his next visit.

There are probably not a few physicians of large obstetrical practice who have met with surprises under similar circumstances, but let us hope that not many have had an equally ridiculous experience.

TREATMENT OF INFLAMMATION OF THE MAMMÆ.

BY

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As soon as inflammation of the breast is certainly made out, the first duty of the attending physician will be to discover the cause, if possible, and to remove it. Careful examination of the nipple should therefore be made for

any cracks, fissures, or abrasions, since these are so often the cause of deeper-seated inflammation, and such lesions should receive the treatment appropriate to whichever may exist. A careful and thorough examination should be made of the extent of the inflammatory process, since different treatment will be indicated according as to whether the inflammation is deep-seated in the parenchyma of the breast, or, more superficially, in the superficial connective tissue.

In the latter case there is usually but little suffering comparatively, seldom enough to prevent the mother from nursing her child, and therefore the notice of the physician is not often called to the trouble until it has advanced to a stage of suppuration, or is so far advanced that suppuration is inevitable. Under these circumstances the treatment called for is simply the application of such means, such as poultices, which will encourage rapidly the formation of pus, which should be evacuated as soon as discovered by incision into the abscess, made in the line of the milk-ducts and running toward the nipple.

This usually ends the trouble unless there have been several points of inflammation. If there is not much pain from nursing or in the opening of the abscess, no communication has been made with the nipple by the cutting open of a milk-duct, so as to permit the mixture of pus with the milk, the woman should be encouraged to continue nursing her babe, while all proper care is given to any trouble that may exist in the nipple.

Should the inflammation, however, be found to extend down deep into the parenchyma of the breast, that form which is more frequently found to exist at the puerperal period, the indications for treatment other than those already pointed out in the removal of the cause are to bring about rest and freedom from pain, the object of the treatment being, if possible, to bring about resolution, and thus leave the organ in a condition to continue its function.

The rest must be absolute. Rest from functional activity, rest from handling, rest from the dragging of its own weight, and at the same time rest from pain with its accompanying feverishness and restlessness.

To bring about this rest the physician must first order the woman to stop nursing from the inflamed breast entirely, and furthermore, forbid all rubbings, friction, or use of the breast-pumps to remove the milk under the mistaken notion that the retained milk is the cause of the inflammation, and he should watch carefully that his orders in both respects are obeyed.

In the early stage of the inflammation, and while resolution is possible, I think all medicinal applications are useless, though I have at times, in accordance with the advice of some, made use of Deshler's Salve, iodide of lead ointment, and belladonna ointment. I am fully convinced, however, that useful as such applications may be in the condition of engorgement preceding inflammation, they are of no use when the latter has occurred.

Particular warning is to be given against the use of hot poultices, for so long a time as resolution is possible, as they only favor suppuration, and their prolonged use has the effect to soften and make boggy all the structures.

The method of treatment that I have found most satisfactory has been that of bandaging. The breast is first covered with cotton wool, and a bandage well and carefully applied, with sufficient pressure to uphold the breast by its support from the dragging weight so much complained of by women, and at the same time by its compression it keeps the breast perfectly quiet, and is further useful if applied by the physician himself, as a guard against meddlesome interference by the nurse or by some well-meaning but mistaken relative. This bandage should be carefully applied new each day, and will, with the appropriate homœopathic remedy, frequently produce resolution in three or four days, when nursing can be carefully renewed and continued.

Should the inflammation continue and, instead of resolution, suppuration occur, a condition of things which may be suspected if the fever and pains continue a number of days, notwithstanding the rest, bandaging, and exhibition of the indicated remedy; and may be diagnosed with certainty, if the fever which has declined suddenly increases, and with it there is an increase of pain, with chills or chilly sensations, while the swelling becomes softer and more boggy feeling to the touch, and more superficial in appearance, the use of the bandage may be done away, and warm flax-seed poultices applied, changing them often enough to keep up a constant application of moist heat.

As soon as pus can be discovered and located, the abscess must be opened and free exit given to the pus.

If it be superficial, it is easily opened by a linear incision, running in the line of the milk ducts toward the nipple. If the situation is deep, it may be necessary to etherize the patient. An incision is then made through the skin and superficial fascia overlying the most prominent part of the swelling; a grooved director should then be forced through the tissues into the abscess, and along the groove of the director a pair of ordinary dressing forceps be guided into the abscess, when by opening the handles the tissues will be pushed far enough apart to give exit to the pus.

If there are several abscesses each must be opened in this way, and if there are dependent pockets from which pus can not flow by its gravity, counter openings must be made at the most dependent positions, until there is secured a free drainage; as otherwise, notwithstanding the openings, the pus will decompose and burrow, causing fistulous tracks and constitutional symptoms.

In those deep-seated abscesses, drainage tubes must be used, and the track of the abscess washed out daily with boiled water, until such time as the water flows back clear, when they may be removed and the breast carefully bandaged and compressed.

The most satisfactory manner for producing this compression is the use of a compressed sponge, as suggested by Gross. His method is to take a clean flat compressed sponge and envelop the breast already covered with cotton wool, with it. A neatly fitting bandage is then applied, and water introduced through the bandage into the sponge, which, swelling, causes an even compression of the breast, relieving the engorgement and at the same time pressing together the abscess walls.

In certain rare cases the inflammation and suppuration occur in the connective tissue between the thorax and the breast. When this is diagnosed by the deep-seated character of the pain and swelling and by the manner in which the breast is lifted up and pushed away from the thorax, the abscess must be opened as soon as pus is suspected, without waiting for any pointing, as from its locality there is great danger of extensive damage resulting from the burrowing. The breast is lifted away from the thorax and the opening made from below at the most dependent position.

I have said nothing about the use of remedies to be given internally, beyond the direction to give that which is best indicated, because I have no new remedy or remedies to propose, and cannot feel justified in an article like this in taking up space with a copy of matter, already well written up in our repertories and text-books.

It is undoubtedly a mistake in my opinion to pin one's confidence alone on the homœopathic remedy, in cases of this kind, to the neglect of procuring rest to the parts by bandages, rest being always indicated to all inflamed parts; and I think on the other hand, that it may safely be considered as equally unwise, to depend only upon the mechanical treatment to the exclusion of the homœopathic remedy; but with the two in combination and with the exclusion of all useless local applications, I have found but a small number of cases where I have failed to bring about resolution. But it must not be forgotten that when it does fail and

suppuration does occur, it takes the cases out of the domain of medicine into that of surgery; and that to prevent the mischief that confined and burrowing pus will cause, in tissues so easily burrowed through and destroyed, the knife must be used and used early.

LACERATION OF CERVIX UTERI.

BY THE LATE

F. S. FULTON, M.D.

(Continued from page 360.)

Varieties and Degrees.—Any portion of the cervix is liable to rupture during delivery. The laceration may be unilateral, bilateral, anterior, posterior, stellate, or internal. When unilateral, it involves only one side of the cervical tissue, leaving the opposite side intact. The side most usually implicated is the left. Emmet's statistics for the cases in which it is recorded as to what form of laceration existed, show the following results: Right side, 15.7 per cent.; Left side, 40.7 per cent.; Bilateral, 39.5 per cent.; Posterior, 4.0 per cent. From the large number of cases, however, in which it is not stated as to the variety of laceration, we cannot regard these results as correct, as in other statistics, as well as in my hospital experience, I found a very much greater proportion of bilateral lacerations than are reported here.

Dr. T. A. Reamy, of Cincinnati, Ohio, in an article which appeared in the *New York Medical Record* of May 10, 1884, reported 223 cases of laceration, with the following results: Bilateral, 170; unilateral, 30; stellate, 16; posterior, 5; anterior, 20.

Extending into cervico-vaginal junction, 15.

With perineal laceration also, 167.

Small sphincter damaged, 15.

Recto-vaginal septum opened, 7.

Perineorrhaphy subsequently in, 50.

I believe that these statistics would much more nearly represent the proportion of the different forms of laceration.

Fig. 3 represents a right unilateral laceration (all the cervix cuts represent the appearance with the patient in Sims's position upon the left side). When the cleft involves only one side of the cervix the erosion of the lips is confined to the side on which the lesion exists. A superficial erosion usually develops upon the everted surfaces without involv-



Fig. 3.

ing the remaining portions of the cervix. If bilateral, the laceration extends across the entire width of the cervix, and may involve merely the endo-trachelian and cervical mucous membrane, together with the superficial fibers of the muscular tissue beneath, constituting what is arbitrarily classified as the first degree of laceration; or the tear may penetrate deeper and involve about half of the substance of the cervix from the os to the vaginal reflection, constituting the second degree; or it may extend still deeper through the entire tissue to the cervico-vaginal junction or even beyond, constituting the third, or worst, degree.

Figs. 4 and 5 show the second and third degrees of bilateral laceration.

In certain very difficult obstetrical cases, this lateral laceration may be so great as to extend entirely through the neck and body of the uterus into the cellular tissue between the folds of the broad ligament. This exceedingly dangerous accident may exist when the mere superficial fibers of the cervix do not disclose more than an ordinary laceration. Violent hemorrhage is apt to follow this extensive tear. After the uterus has contracted and checked the external flow of blood, it may still continue to discharge into the cellular tissue of the broad ligaments, forming a hæmatoma of no mean proportions, which not only causes exhaustion



Fig. 4.

and nervous shock, and establishes a violent peritonitis or cellulitis, but, by subsequent breaking-down and formation of an abscess, opens the way for pyæmic infection and death by septic peritonitis.

In the *American Journal of Obstetrics*, April, 1884, Dr. W. W. Seymore reports two cases of septicæmia following parturition, in both of which laceration into the broad ligaments, with the formation of a hæmatoma, was discovered by the passage inward of the sound into the substance of the ligament a distance of between two and three inches, followed subsequently by the partial rushing out of clotted blood, and later by septic infection. An autopsy

revealed the nature of the accident as stated above. No doubt that many cases of septic peritonitis following parturition have as their origin an undiagnosed internal laceration of the uterine tissue, extending more or less deeply into the surrounding structures. When the tear extends forward through the anterior lip, as is not usually the case, it is generally healed spontaneously, if cleanliness is observed. It may extend but a short distance, or it may be so extensive as to open a passage into the cavity of the bladder. This will heal to a certain extent, sometimes entirely with the exception of leaving a small vesico-uterine



Fig. 5.

or vesico-vaginal fistula, for which the appropriate operation must be performed. In rare cases the cervix will heal after such an accident, leaving a small fistula which opens into the cavity of the uterus, and through which the urine is continually finding its way.

If the rent occurs posteriorly only, it is usually healed spontaneously; sometimes, however, with the formation of a dense mass of cicatricial tissue. It may extend into the rectum or into the cul-de-sac of Douglass, in either of which cases it makes a very formidable complication.

The stellate laceration, as shown in Fig. 6, is one in which

the rents extend into the cervical tissue, from the os uteri as a center, it being not infrequent to find as many as four or five different tears. These clefts can be discovered radiating in all directions from the os, some filled entirely with cicatricial tissue, others gaping; with exuberant granulations covering some of the everted surfaces, and hard nodosities disfiguring others, and all to a greater or less extent covered with erosions, from which is constantly poured a thick, yellow, or pearly leucorrhœa, which in time produces a profound condition of anæmia. The os is patulous, the lips everted, and the whole cervix and uterine

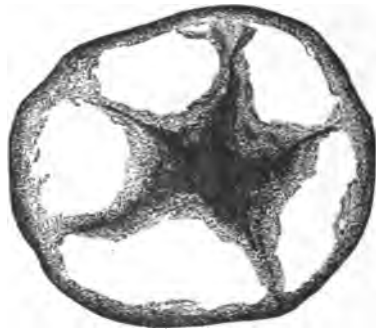


Fig. 6.

body hyperplastic and lay down upon the floor of the pelvis.

The only other form of laceration which is of significance is that in which the fibers of the internal os and cervix are torn internally, without any outward evidence of existing lesion except a patulous os and prolapsed endo-trachelian membrane. The diagnosis can only be determined by examination of the cervical cavity with the sound and finger. This seems to afford all the evil consequences of other lacerations.

At other times severe cervical tears will be filled up with such a large amount of cicatricial tissue, causing such extensive subsequent contraction as to nearly obliterate

the healthy cervical tissue, leaving these hard nodular masses of scar tissue projecting from the surface, closely resembling a small fibroid in the substance of the cervix.

Symptoms and Effects.—The average length of time in which symptoms become so distressing as to drive the sufferer to the physician for relief is about five years. It is not infrequent, however, for the patient to feel the bad effects of the laceration from the time she leaves her bed until she submits to the operation. At others, aside from a malaise from which they suffer, they may notice no inconvenience for several years, except the tendency to abort, which was not their habit previously. After a time symptoms begin to manifest themselves. The patient will be unable to undertake her usual amount of exercise or work. Slight exertion brings with it an unwarrantable amount of fatigue. She will shake and tremble for hours after walking a comparatively short distance. There is a dragging weight in the pelvis, oftentimes a severe bearing-down drives the patient nearly frantic. As the uterus becomes heavy from its condition of hyperplasia and subinvolution, the natural tendency is for it to become retroverted; in which case the heavy and enlarged fundus is thrown over against the sacrum and rectum, causing the dull, dragging backache, with not infrequently tenderness of the sacral or lumbar portion of the spine.

It also produces a condition of partial stenosis of the rectum, obstructing the passage of the excrements and inducing an obstinate form of constipation. Both from the mechanical pressure upon the sacral nerves and nervous disturbance produced by the laceration itself, there is developed all forms of sacralgia, and neuralgic pains in the limbs, more generally extending from the small of the back through the pelvic structures, and downwards over the anterior surface of the thighs, sometimes reaching to the calf of the leg, but more usually stopping at the knee. The spine is the seat of a dull, dragging pain, or at times

sharp neuralgic darts. It gives out easily on effort, seems to have scarcely strength to sustain the weight of the body, and if required to do so for any length of time fails utterly, not infrequently prostrating the patient for days. The ovarian and hypogastric regions are usually more or less sensitive to pressure, and the seat either of sharp, darting pains, usually extending across the abdomen; or of a dull, aching distress, which is just as annoying. At other times a persistent form of sciatica is developed, which of course resists all forms of medicinal treatment. As a consequent of the laceration, cellulitis is usually developed, which is evidenced, if it occurs early, by stoppage of the milk secretion, great pain and tenderness, fever and strong disinclination to move on account of the pain occasioned. When the cellulitis results in bands of adhesions being formed, binding the uterus backward, as is most common, or laterally, it produces a displacement, with its entire coterie of symptoms, which is most intractable.

Every variety of menstrual disturbance known to woman is produced by this lesion. In 17.80 per cent. of the cases recorded by Emmet, menstruation remained unchanged as at puberty; 44.74 per cent. had the flow either lessened, increased, or made irregular as to quantity, without alteration in the length of time of menstruation. In 62.55 per cent. the time remained unchanged as at puberty. In 82.17 per cent. the menstruation was altered as to quantity, the flow being either increased, diminished, or irregular, and of these 62.8 per cent. had their menstruation increased. In the great majority of cases pain attends the monthly flow; most frequently it is felt with greatest intensity at the beginning, lasting for the first day or two, and then gradually subsiding. All the symptoms, distressing at all times, are aggravated at this time. The ovaralgia, sacralgia, sciatica, abdominal pain and tenderness, backache, distress in the limbs, become intensified to a great discomfort or to an almost unbearable distress.

As a result of the condition of the lips, their consequent erosion, the hypersecretion of the endotrachelian mucous membrane and the cervical follicles, a profuse leucorrhœal discharge generally results. This may be either profuse or scanty, bland or excoriating, of any describable color or consistency. But it is generally depleting, and aggravated before and after menstruation. The cervix generally undergoes to a greater or less extent septic degeneration from stopping up of the mouths of the Nabothian glands, which can be detected as small, hard, distended follicles projecting from the surface of the cervix, and which, when punctured, are found to contain a quantity of clear, transparent, gluey, gelatinous mucus. These small follicles, by enlarging and pressing upon the cervical nerves, will not infrequently cause great reflex nervous trouble, as sickness at the stomach, loss of appetite, sadness, lachrymose condition, great nervousness, neuralgic headache; all of which will generally be relieved by puncturing, evacuating the cysts, and obliterating them with iodine. As stated before an erosion generally forms, which looks dingy and red, and may extend as far as the cervico-vaginal junction. This must be healed before any operative measures are resorted to. There is a condition, evidenced by the sound and examining finger, of hyperplasia and subinvolution of the entire uterus. Coition is painful and not infrequently attended with hemorrhage.

When the laceration first occurs, before the plugs of cicatricial tissue are deposited in the angles of the cleft, the woman is apt to be unusually productive; one impregnation succeeds another with great rapidity, only to be aborted about the second or third months. This condition of affairs is especially apt to supervene after a large stellate laceration. The reason of this is plain, when the large patulous os, the softness of the cervical tissues, and the great facility which is offered the spermatozoa to enter the uterine cavity are considered.

This habit of aborting generally persists until the cleft is filled with hardened tissue and a heavy thick leucorrhœa is developed, which occludes the passage, when impregnations usually cease and absolute sterility follows.

71.34 per cent. of the women suffering from laceration of the cervix, examined by Emmet, were sterile, and there is no proof that a single one became pregnant after a bilateral laceration; and, as stated above, if they do become impregnated, it is only a pseudo-fertility, as the uterus possesses no power to carry its contents to full term.

If the laceration be anterior or posterior and severe enough to enter the bladder or rectum, in addition to the cellulitis or peritonitis established, the excrements from one viscus or the other will find their way into the vagina. As a result of all these depleting conditions a profound condition of anæmia is at length developed; the patient becomes thin, weak, sallow, cachectic, and almost resembles one affected with chlorosis. The climax is generally postponed; in cases where the menstruation is persistently lessened, it may be hastened. In either case from the depleted condition and profound anæmia of the patient, her system does not seem to be able to withstand this great revolution in her physical organism, and she easily falls a victim to early developed phthisis or epithelioma. In women of a spare, rather fragile build, the danger of phthisis is always to be remembered in advising the patient regarding treatment. On the contrary, those patients not unusually suffer from epithelioma of the cervix, who have had the least impairment of their general health previously. Aside from these conditions, which are largely local, many reflex nervous troubles are developed, which are more distressing than all the others. In almost every case there is a most persistent cephalalgia; its usual seat is in the occiput, where it exists as a dull, heavy ache, as if the person had been struck with a club in that locality. It may occupy the vertex or forehead. It is usually a sort of a crazy ache, or of such intense character

as to entirely prostrate the woman. She thinks she is going crazy, and, in fact, her mental strength is somewhat impaired. Her memory is weaker, and she can use her faculties for only a short time without great exhaustion.

The following case is important, as illustrating several important features of symptomatology and effect :

CASE—Mrs. A., aged forty-three, stout, though well proportioned, came first under my care October 10, 1886. At that time she was complaining of what had been diagnosed and treated as malaria. She was chilly, with shivers creeping up the spine; occipital headache of a dull, heavy, distracting character, extending down the back towards the shoulders; the eyes were sore and heavy; she was restless, and, to a great extent, sleepless at night, lying awake not from any distress, excepting very frequently her headache, which at times became very intense and occupied the entire head, preventing her sleeping. Quite contrary to the usual custom her back and limbs troubled her but very slightly. She was excessively nervous and despondent, the slightest disturbance or extra demand upon her time or nervous force proving quite sufficient to almost prostrate her. The reception of a few friends would completely unnerve her. Although she had a beautiful home, a most devoted husband and family, and everything to make life happy and enjoyable, she was continually despondent and frequently gave way to violent fits of crying, which greatly distressed herself and family. She was aware that there was no reason for it, but said that it was entirely beyond her control. She complained also of dizziness, which was markedly worse in the morning, as indeed were nearly all the symptoms. The periodicity was so marked that, taken in connection with the chilliness, which almost always preceded or attended the exacerbations, it was not to be wondered that a diagnosis of malaria was rendered.

An examination was not at once made, but on November 1, becoming convinced that her sufferings were due to

a more definite cause than the hydra-headed malaria, I made a careful examination with the patient in Sims's position. The uterus was high up, with the fundus tipped forward; pressing the cervix well back into the posterior cul-de-sac. The entire uterus was hyperplastic and boggy. No sound was used at the examination, as the more I become acquainted with that instrument, even in the hands of skillful manipulators, the more I distrust it. I do not regard it as a safe instrument, as I am confident that in my hands it has several times been the cause of acute attacks of pelvic inflammation, though the greatest care was used in its manipulation. So many women present themselves to the gynæcologist with the history of acute inflammations excited by the passage of an instrument into the uterine cavity, that its use should receive a well-deserved condemnation. Besides, I believe, as Dr. Tait says, that "the physician who can not ascertain the position of the uterus and its relative size without the use of the sound is either a novice or one unfit to practice gynæcology." It was very difficult to bring the cervix into view, as it appeared bound back by strong bands of adhesion, which could be felt by the finger in the posterior cul-de-sac, and also seen when the cervix was forcibly drawn downwards and forwards with the tenaculum. The anterior lip was almost black from venous congestion, very greatly hypertrophied, and so soft and pulpy that it was difficult to distinguish the exact line of junction between the cervix and the anterior vaginal walls. It was precisely the condition which would naturally precede the development of a malignant neoplasm. It bled profusely upon being punctured with the scarificator. The mucous membrane and the entire cervix was intact, no eversion being present. Numerous cysts filled with the characteristic gelatinous, sticky secretions, dotted the cervix. There was comparatively little eversion of the lips, and excepting the hypertrophied anterior lip, were in very nearly normal relation to each other.

The entire cervix was greatly enlarged and hyperplastic. Upon drawing the uterus down and forcibly separating the lips, two dense hard bands, of white and glistening appearance, could be plainly seen connecting the lips and thus preventing the characteristic eversion.

There was comparatively little tenderness, and no evidences of cellulitis, although the cervix itself was more sensitive than normal.

When the examination was completed the cervix was freely punctured, relieving it of its engorged condition and emptying the cysts, the whole painted with Churchill's iodine, and a cotton tampon soaked in glycerine applied to the cervix. She was directed to take a hot water douche of about a gallon, night and morning. It was to be used with the patient in the dorsal decubitus, with her hips elevated upon a large bed-pan.

Local treatment was given over a week, and internally she was given *cimicifuga* tincture, to be taken every two hours. This plan of treatment was persisted in till February, at which time the cervix was reduced greatly in size, the hypertrophied and engorged anterior lip was greatly reduced in size and of normal color and consistency. The cysts had disappeared from the cervix, and the hard bands which bound the cervix backward, or which at least gave tactile and ocular evidence of having once done so, had to a great extent disappeared and allowed the cervix to be dislocated downwards with comparatively little effort. Her symptoms were greatly ameliorated, though at every menstrual period she had her old trouble.

I expected to operate after her February menstruation, but sickness in the family and her own illness from follicular tonsillitis postponed the operation till a month later. Treatment was continued. Four days after disappearance of her menstruation, assisted by Dr. H. M. Banks, of Englewood, Dr. Jno. B. Garrison, of New-York, Dr. Cox, and the nurse, I operated after the manner de

scribed under the head of operating, cutting up upon the somewhat everted lips, and dissecting very deeply into the uterine body to remove the hardened tissue which filled the gap and which was densest and most abundant upon the side which formed the uterine canal. The circular artery on both sides was cut, and the hemorrhage was, of course, proper for a cervix operation. The cicatricial tissue was all removed, though it was necessary to cut over an inch directly into the uterine body. The lips were approximated and held together by six silver-wire sutures, three on a side, the ends cut short and bended over towards the os along the line of incision, the uterus replaced, irrigated with the bichloride solution, 1 to 2000, which had been used freely both as a douche and as a fluid in which to wash the sponges, and the patient put to bed. All hemorrhage stopped by the approximation of the lips. The sutures were placed as near the angle of the wound as possible. The stitches were removed the tenth day; there never having been any fever or pain, except a slight sense of strain in the inguinal and hypogastric regions, and the lips found to be perfectly united. After the first night, she slept every night, sleeping nearly all the time for the first twenty-fours after the first night. Her headache had left her, she felt no nervousness or inclination to weep, and said on the fourth day that she thought she might get up as she felt perfectly well.

This case was illustrative in many ways. She had borne three children since the one, judging from the puerperal fever, stoppage of milk, milk legs, etc., which followed that delivery which must have occasioned the laceration. Of its occurrence at that time I have no doubt. If it be correct, it shows that the most violent laceration need not entail sterility. It also shows with what rapidity the relief of the symptoms at times follows the operation. It also makes apparent, I believe, the necessity of removing the entire cicatricial mass, even if the dissection has to be very deep

into the uterine tissue. The depth of the dissection is of little importance, nor is the severing of the circular artery to be feared. The one thing to be apprehended is that the diseased tissue, whether it consist of hardened cicatrice or tissue which has undergone cystic degeneration, shall not be entirely removed and the coaptation of the lips rendered easy and natural.

In addition to the characteristic symptoms as presented in the above case, certain unusual, indirect, reflex troubles at times owe their origin to severe lacerations, as for example: Dr. Mann, of Buffalo, reports a case of anuria of five years standing which was entirely relieved by an operation upon the cervix. Dr. H. W. Songyear, of Detroit, reports a case of persistent salivation which was relieved in a similar manner; the salivation disappearing five days after the operation. Dr. R. S. Sutton, of Pittsburg, Pa., has recorded a case of cataleptic convulsions cured by trachelorrhaphy. In this case the convulsion cured could be induced at will by pressure of the finger against the angle of the laceration. The convulsions did not recur after the operation. Dr. Emmet records three cases where persistent sub-orbital pain of long standing has been removed by trachelorrhaphy. In two of these the pain was induced by pressing on certain portions of the cervix, making evident the cause of the pain. Dr. Paul F. Munde reports a violent case of hemicrania, and also one in which the patient would fall into a profound sleep on every act of coition, which were cured by a repair of the cervix. In the latter case the patient fell into this deep sleep during the progress of the examination upon exploring the deep bilateral laceration. The excision of the cicatricial plug and the uniting of the lips entirely relieved the patient. Beyond a doubt a large number of neuroses are attributable to the existence of a severe laceration, but the surgeon who operates upon all cervixes which are cleft with the expectation of relieving some re-

flex neuroses which may be coexistent, will meet with many and bitter disappointments.

Diagnosis.—This must be reached by means of both the finger and eye. Neither alone is quite sufficient. Where the finger is introduced, it will generally find the uterus prolapsed, retroverted, and in a condition of subinvolution; the finger will detect the patulous os, the cleft angles of the laceration, and usually the cervix studded with little cysts presenting as hard, nodular bodies above the cervical mucous membrane. The finger will also usually be able to detect the abrasion of the mucous membrane by the absence of the soft, smooth feel of the healthy cervix. There will usually be more or less tenderness from existing cellulitis. The variety of the laceration can usually be detected by feeling the different clefts, or the hard, stringy bands of cicatricial tissue which have filled them.

In the use of the speculum there is a great deal of choice. If the tubular one is used, the vaginal tissues are generally pushed forcibly back, not infrequently carrying with them the posterior lip of the cervix, so that the appearance through the speculum is of a raw ulcerating surface. The natural ectropion is greatly increased, and no true idea can be gained of the proportionate amount of laceration and healthy tissue. The bivalve speculum is very much better, and affords a much truer view, but even here the natural erosion of the lips is greatly increased, and it is usually very difficult, if not impossible, to successfully approximate the lips in order to accurately determine the amount of laceration. The Sims's removes this difficulty. With the patient in Sims's position, the vagina ballooned out and the perineum retracted, there is nothing which offers any traction upon the cervical flaps. It presents itself to the eye exactly as it is.

The relative tear, ectropion, and erosion can be accurately estimated. Then, by hooking one tenaculum into the anterior flap and a second one into the posterior, by care-

fully approximating them and turning in the eroded surfaces, it is possible to estimate the exact extent of the laceration. By the traction of the tenacula the normal conicity of the cervix is restored. If the lips cannot be turned in or approximated, there is no laceration; if they can be, the amount shows both the degree of the erosion and the extent to which the flaps will have to be denuded and stitched together in the reparative operation.

Having completed the diagnosis, the next question is when to operate, as statistics show that only about 50 per cent. of the cases of laceration require surgical treatment. If there is simply a slight laceration, without marked erosion of the lips, a slight amount of cicatricial tissue in the angles of the cleft, with a healthy mucous membrane, even if there be nervous symptoms and a certain degree of anæmia, there is no indication for operating; and, if it were performed, would probably be only disappointing in its results. When, however, there is marked ectropion, more or less extensive soreness, deposit of cicatricial tissue in the cleft, cysts of the cervix, leucorrhœa, with menstrual disturbances, anæmia, and reflex nervous troubles, as mentioned above, appearing as sciatica, ovaralgia, cephalalgia, neuralgia of various forms in different portions of the body, or, as in some of the cases cited, anuria, catalepsy, chorea, suborbital pain, etc., to which no assignable cause can be given aside from that afforded by the existence of a well-marked laceration with the above distinctive marks, the probability is that an operation will be followed by most brilliant results. There is no doubt of its being indicated in those cases.

In women with a phthisical or cancerous history, an operation is not infrequently demanded as a prophylaxis against the subsequent invasion of either of these terrible maladies. Even when symptoms do not demand it, an operation should be performed in every case of extensive laceration with more or less nodular hyperplasia, particularly if the woman

has been unusually prolific and has behind her a history of carcinoma or phthisis.

A marked degree of cellulitis is a contra-indication to an operation, unless the surgeon is well satisfied that it is originated and perpetuated by the laceration.

Emmet says that, as long as any tenderness can be detected by digital examination, it is unsafe to operate, but I cannot accept this statement, as to relieve the cellulitis would require a much longer time than most women can wait, and, besides, of very many operations performed in cases in which more or less tenderness was easily discernible, we have never yet seen a patient have more than a slight exacerbation of the trouble, from which she recovered speedily and was free from any additional evidences of cellulitis by the time it was proper for her to sit up.

An operation immediately after delivery will be found usually impracticable, and even if it could be done, I do not believe it would be advisable.

The parts are swollen, œdematous, so soft as to be almost indistinguishable from the vaginal walls, and all the parts are so distorted as to make it exceedingly difficult to properly approximate and suture. Added to this is the danger of subjecting a patient already exhausted by parturition to the depressing effect of the ether and its subsequent vomiting, and also of seriously disturbing the child's stomach by forcing it to take the mother's milk saturated with ether, or else to resort for the time to cow's milk or artificial feeding, which is not what the child needs. The better time to operate we believe is after the uterus has become reduced in size and the cervical mucous membrane has regained its normal pink appearance. The flaps will then be clean and hard and capable of yielding satisfactory results. In ordinary cases the most favorable time to operate is the third day after menstruation. The operation at this time is less apt to induce menstruation, which is of very

common occurrence if it is postponed. As is true in all surgical proceedings, February and March are not as favorable for operation as other seasons of the year, owing to the poisons which accumulate in the atmosphere at that time, and also to the system being generally somewhat exhausted by the winter's work or dissipation, and feeling the enervating effect of approaching spring.

In hospitals this is particularly true. The many operations, the large number of suppurating wounds, the presence in crowded wards of a large number of patients with all sorts of diseases, contaminate the air, so that it is not only unfavorable to speedy union but strongly predisposes to all forms of low suppuration and sloughing. A chronic condition of "hospitalism" arises, which militates strongly against both the success of surgical procedures and the rapid recovery of the patient.

THE REMEDIES FOR IRREGULAR MENSES.

BY

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There are certain medicines in our *Materia Medica* whose action over the menses, as relates to time and quantity, seem very contradictory. In one proving they cause profuse and too frequent menstruation; in other cases, the menses delay and are profuse; in still other instances, they are delaying but scanty. This contradictory action has been a puzzle to many practitioners, and has not been explained. It has been supposed that when the menses are too frequent and profuse, the cause was a condition of irritation in the uterus or its appendages. If the menses were too frequent and *scanty*, it was because of a sub-normal con-

dition of irritability. Infrequent or delaying scanty menses may be due to the same cause. But how shall we explain the cause of delaying profuse menses? Delaying menses are often caused by congestion of the spleen, liver, or lungs. When these congestions disappear, the menses appear, often too profusely. The local cause of all these irregularities as to period and quantity has not yet been explained. It is certain that those medicinal agents which cause these irregularities cannot cause them by inducing local lesions or congestions of other organs. It appears to me that they can only cause them by the influence they exert on the central nervous system influencing the vasomotor or the sympathetic.

Our repertories do not agree as to the remedies for irregular menses. Allen ("Index Register") says, *aur. s., graph., iod., merc., mosch., nat. mur., nux mosch., op., plumbum, sabina, tab.* Jahr ("Diseases of Women") does not mention irregular menses. Nor does Lilienthal. Hempel ("Symptomen-Codex") mentions only *castoreum* and *gentiana c.*, as causing irregular menses. Guernsey's *Obstetrics* does not give any remedies for irregular menses.

I can find no author who gives definitely the remedies for such a disorder; yet every practitioner who has treated the diseases of women to any extent meets with cases, when for a series of months a woman's menses may be too scanty and frequent; then for a time they will be too frequent and profuse. Another class of patients will have delaying menses, too profuse for a time, then delaying and scanty. On examination with speculum, no local cause can be found for these abnormalities. The causes, in fact, lie in the nervous system. The patients are generally hysterical, or neurotic, or both.

My observations in gynæcological practice, and a study of *materia medica* for many years, have convinced me that we have but few remedies for irregular menses. I mean an irregularity as to period and quantity—an irregularity not

caused by any local lesion, or congestion of other organs. The most important of these medicines are:

Aurum, Calcareæ, China and its alkaloids, *Pulsatilla, Manganese, Senecio, Sabina*.

Aurum is one of the most important, and, like all the others mentioned, causes primarily profuse and frequent menses. This it does by acting on the vaso-motor nervous system, causing a dilatation of the arterioles in the ovaries and uterus, thus allowing a larger afflux of blood to those organs and a heightened irritability. (Platinum also resembles gold in this respect; and when indicated by its symptoms, which are almost the opposite of gold, should have the preference.) But if the influence of gold is long continued, and then suspended, an opposite condition obtains, and the menses become pale, scanty, and delaying, owing to the anæmia and torpor of the ovaries and uterus. When given for profuse and frequent menses, the dose should be small, 3x to 6x, and continued through the intermenstrual period. When scanty and delaying the dose should be more material, so as to get its primary physiological, but not its pathogenetic, effects. Give the 2x or even 1x trituration, and good results will follow.

Calcareæ.—According to Hahnemann's dictum, this drug should only be used when the menses are too soon and profuse; but it cannot be prescribed for this symptom alone. We must have the lymphatic temperament, and the strumous diathesis, and other characteristic symptoms. This is true as to calc. carb., but in my practice I find that calc. hypophos. is often more useful in this condition than the former; and I have also found that it is often indicated in *scanty* menses, sometimes too frequent, and sometimes too late; but the dose for profuse menses should range between the 3d and 6th, while in scanty menses the dose should be the 1x or 2x trit., repeated three times a day all through the month.

China will often regulate the menstrual periods when oc-

between the periods; in eleven there were good results, in ten no improvement. In eighteen cases there was very marked improvement in the amount of pelvic pains, and frequently the patients stated that they felt much stronger during the periods, and were not 'so pulled down.'

"In estimating the value of these general results it must be remembered that in the inquiry the permanganate of potassium was prescribed indiscriminately, with the view of testing its action; the failures are, therefore, more numerous than they otherwise would have been had cases deemed most suitable been selected. Thus, a number of them were cases of chlorosis, where iron should first have been employed or given in conjunction with the manganese."

Dr. Stevenson further claims that permanganate of potassium is extremely useful in checking leucorrhœa, and in twenty-nine cases which were subject to menstrual headaches in only four of these was no relief obtained. Further, it is claimed the permanganate will relieve ovarian pain; and of twenty-two cases in which ovarian pain was a special symptom, the relief is stated to have occurred in all to a more or less degree. What appears to be an entirely new point, and one which, from our point of view, is almost inconceivable, is the author's claim that in twenty-seven cases in which menstruation was in excess, either in time or in quantity, in two cases only was there no improvement in this condition under the use of permanganate of potassium. In fact, the author claims that the beneficial effect in this respect is even more marked and reliable than in the opposite condition of suppressed or scanty menstruation. Dr. Stevenson believes that "this contradictory action of the drug is due to correcting the constitutional states which give rise to menstrual derangements rather than to any specific effect on the uterine structures. Perhaps, also, some of the relief to menstrual suffering afforded by the permanganate is due to the improvement in vascular action."

These observations may be of some value to us, until we have some provings made by women whose generative organs are healthy. The "contradictory action" mentioned above cannot be explained until we have such provings. The binoxide can be substituted for the permanganate, but it is probable that the potassium element is a prominent factor in the production of many of the effects of this drug. The binoxide is tasteless, and quite incapable of causing unpleasant effects. In one case of scanty and anticipating menses it effected a prompt cure. I used the 1x trituration, two grains three times daily for a week previous to the expected menses.

Senecio.—This indigenous plant, whose name implies its influence in menstrual disorders, is known among the people by the name of "Female regulator." Its active principle is an oleo-resin—*senecin*. In domestic practice it is considered a panacea for all menstrual irregularities. I have used it for more than twenty years, and speak with confidence when I say that, given in proper doses, it is equally useful in premature and profuse, as well as scanty, menses. Equally useful in delaying menses, be they profuse or scanty. To be effectual it should be given in small doses, usually three times a day during the week or two before the menstrual period. I prefer the *senecin* to the tincture. It is now prepared in tablets, from the 1x to the 6x. The 1x I prefer when the menses are scanty; the 3x or 6x when they are profuse. There are not many concomitant symptoms, but urethral and vesical irritations, and a tendency to pulmonary hæmorrhage, are the most important.

Sabina, while it resembles *senecin* in many respects, is a more powerful medicine. We have a good pathogenesis of it, abounding in characteristic symptoms. I use it as I use *senecin*, giving the 3x and upward when there is menorrhagia, with a condition of ovarian and uterine irritation and active congestion, and the lowest attenuation when a con-

dition of torpor obtains instead of irritation. It is a close relation to thuja, both botanically and pathogenetically.

We now know that many cases of uterine, ovarian, and tubal diseases are due to gonorrhœal poisoning. Such cases are characterized by the most intractable uterine discharge, with menorrhagia. In these cases these two remedies can be used with more success than any with which I am acquainted.

Their internal use should be aided by their topical application, either by suppositories, or mixed with glycerine and applied on tampons of wool or cotton.

INJURIES TO THE PELVIC FLOOR.*

BY

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So varied and numerous indeed have been the methods of operations already set forth for these injuries, that I suppose man's ingenuity will find it difficult to invent another good method that shall differ materially from each and every one thus far brought before the profession. And this statement is rendered safer from the fact that later authors have rightly been paying closer attention to the anatomical relations of the parts involved, thus working from the only sound basis for surgical repair.

Nor can I from a comparatively limited experience add much that is new to what has been offered by a long line of able names reaching even into the present year. The subject is a broad one, and I may not presume to tax your patience with more than certain practical questions connected with it. Surely there is much of vital importance

* Read before the Boston Gynecological Club.

attaching to it. Having been much interested in it myself of late, I have hoped it may be profitable for us to review the matter while it is being discussed anew by the profession. Enough for me, if in this paper I shall offer a few good texts from which to hear you preach, for I shall value their discussion by this body which it has been my privilege to join.

First of all, let us agree that there is such a structure as the female perineum, and perineal body too, even if we have to define it simply as a fusing together of perineal structures by accession of elastic tissue, at a point between the vulvar commissure and the anus. While some are even pleased to contend that this body does not exist, all must acknowledge a perineum, and surely a pelvic floor. Hence I have preferred to speak of "Injuries to the Pelvic Floor," and likewise because we have come to recognize more varieties of "laceration" than earlier authors pointed out.

Is it not remarkable that in the whole history of perineorrhaphy very able men have held theories so widely different and even contradictory? If all the diagrams for restorative operations could be printed on one large sheet and brought to our gaze, what object, animate or inanimate, would not there be suggested? Butterfly, or leaf of clover on whose flower it feeds; horse-shoe or crescent; mason's trowel, and high-backed comb.

- Does the perineum support the uterus? And men qualified to speak have answered: (1) Yes, chiefly and directly; (2) But slightly and indirectly; (3) No, not at all.

When found to be lacerated, ought an average tear to be sutured at once? And men qualified to speak have said: (1) Yes, by all means; (2) Yes, if the doctor knows just how to take the stitches; (3) It is sufficient to cleanse the parts, bring the torn edges together, and retain with serrefines; (4) It is enough to thoroughly cleanse the parts, and keep the knees tied together.

This is mixing obstetrics and gynæcology, to be sure;

but in our enlightened day you will agree that, so far as the perineum is concerned, the obstetrician should be a gynæcologist too. Otherwise the surgeon will be needed too often to suit either the pride of the doctor or the pocket-book of the patient. Again, in proportion as he can be gynæcologist will he strive to preserve and restore the perineum. In other words, it is he who knows the difficulties of the secondary operation who will most zealously try to succeed in the primary. So I confidently submit that *no physician* should be content with a preparation that has not included practical teaching in, and thorough acquaintance with, the primary operation for ruptured perineum, acquiring the mode in detail of applying sutures, proper degree of tension, etc., etc.

The points that perhaps we may profitably review this evening are these :

First. What varieties of injury may the perineum sustain in childbirth?

Second. How far can we prevent these?

Third. What constitutes a laceration needing immediate repair by suture?

Fourth. What conditions compel secondary operation?

Fifth. Is there any one method (for incomplete rupture) adapted to all cases, and if so, what is the best?"

To dwell for a moment on the amount of support given to the uterus by the perineum. Though some in high position to-day deny that the perineal body has any part in such support, few will contend that the pelvic floor has not. For if its integrity be so far lost as to allow rectocele to supervene, the structures become a weight from below and even drag the uterus down. So that the mildest claim must insist that at least a negative or indirect help resides in a perineum intact. In other words, it is a help not to be a hindrance. But we can justly claim more than this.

After speaking of the normal action of the levator ani, transversus perinei, bulbo-cavernosus, and erector clitoridis

muscles in drawing the rectum forward and upward, thus narrowing the outlet of the vagina and throwing the same into folds; the vagina by this means maintaining its axis at a right angle with that of the uterus, and keeping the cervix well backward and upward so that the abdominal contents impinge on the fundus somewhat posteriorly, Dr. Marcy (*Am. Journal Obstet.*, Jan., 1889), says: "The general consensus of medical opinion is that the changes which occur in the vagina usually commence with lesions of the outlet and contiguous tissues, dependent upon parturition. A weakness in the base of support, the change of muscular action which causes a drawing upward and backward of the posterior vaginal wall, with an eversion of the vulvar outlet, produces a change in the axis of the vagina, bringing it and the uterus toward a common plane, and then the cervix, instead of being held at right angles, becomes a wedge in line with the vaginal outlet, separating its walls. This change in the position of the uterus causes the weight of the abdominal contents deflected toward the pubes, no longer to fall upon the organ posteriorly, but vertically, and little by little, following the sacral curve in its descent, prolapsus, with varying degrees of retroversion, ensues."

Firstly, as injuries occurring to the pelvic floor in childbirth Dr. Skene's recent issue enumerates:

- (1.) The various degrees of laceration of the perineum, *i.e.*, in the median line of the pelvic floor.
- (2.) Subcutaneous separation of the muscles of the pelvic floor at their junction in the median line, or so-called perineal body.
- (3.) Laceration in the median line and temporary loss of power in the remaining muscles from over-distension.
- (4.) Laceration of the levator ani muscle, occurring alone or accompanied by the lesions already given.
- (5.) Atrophy and permanent paralysis.

Secondly, regarding the prevention of rupture, I think that among candid physicians we shall find many ready to

acknowledge almost the belief that "when it will, it will, and when it wont, it wont" tear. At all events, on more than one occasion my own best care has signally failed to avert a laceration of the second degree. Still, as I have yet to record more than one or two ruptures involving the sphincter, and none into the bowel, together with the fact that many cases have escaped where rupture seemed certain, I firmly believe that manipulation has accomplished something.

At the Vienna General Hospital in 1885, the hebamen in Prof. Gustav Braun's wards were directed in the later stage of labor as follows: With patient always lying on the left side, to sit with left side to the patient's back; to pass the left hand over in front between the thighs and grasp the foetal head; to place the right palm, protected by a moist napkin, against the perineum, the ends to accomplish being a proper retarding of the head, pushing both head and perineum toward the pubes, also with thumb and finger coaxing the perineal tissues toward the median line. Recalling the anatomical arrangement of muscles, the reasons for these steps will be at once apparent, and so far forth may be approved as in accord with science and good sense. The number of extensive lacerations was agreeably small, and yet we may remember that the patients were not American women, but rather the middle and lower class German or Austrian.

Doubtless control of the too rapidly advancing head is the chief factor. Nor do I feel uncharitable when I strongly suspect that practitioners, and beginners especially, are regularly tempted to hasten unduly rather than retard such advance. It is just at this stage that the suffering is approaching its highest point, and an undue anxiety for the safety of the child, together with a laudable desire to end the patient's distress, are factors too often sufficient to lead us into that which we may soon regret. It is sometimes difficult to refrain from using a power so easily at hand;

but it is just that command of self that fits us to conduct the issues of those who trust their health and happiness to us.

To mention in passing two or three practical points: In addition to dragging forward the dilating sphincter and by hooking two fingers therein, I am accustomed to push up over the occiput certain tissues in front that may seem to catch upon it. Again, when the occiput is freed, but the perineum still tightly drawn over the face, I fear to let it snap suddenly over the projecting chin, but prefer gently to rotate the head, allowing the chin to emerge at a point higher up on the labium.

While it may appear somewhat fanciful, I think this accident has happened to me in two cases. Even when the perineum had successfully withstood a greater, though steady, stretching, and I could therefore reasonably expect its continued safety, I have been surprised by that ominous sound of parting tissues, hard to imitate, but easily remembered if once heard; and this has seemingly occurred just as the perineum brought up against the neck after slipping over the chin; or in the recoil, so to speak. By way of illustration, tie in each end of a slip of paper a rubber string; stretch these between two fixed points; pull as on a bow-string, and suddenly let go. It can thus easily be shown that while considerable tension can be safely made, a sudden *release* from such tension is liable to be followed by a break as the string returns to a straight line.

But may not the shoulder be quite as often to blame as the head? Certain it is, that if a tear be once started, this part of the child can easily plow a very deep furrow.

Finally, the left side position offers, I think, another element of safety in taking the weight of the child away from the perineum, gravity helping it in the opposite direction. Hence I have come to prefer this position, though still allowing the patient generally to choose for herself.

Thirdly, in deciding what constitutes a laceration needing

immediate suture, we should hardly trust to the physician who said in my hearing last winter, "I don't think there is any need of tearing the perineum. I've attended three or four hundred cases of labor and have only seen three or four lacerations." You have heard similar statements. This fortunate (?) servant of unfortunate patrons is one of a class lamentably large for this enlightened era of gynæcology.

I have alluded above to the wide variety of opinions as to the treatment of ordinary lacerations. My own custom is immediately to suture any tear involving more than integument and mucous membrane, or a tear one-fourth inch or more in depth. For this, as indeed for most operations on either cervix or perineum, I prefer catgut of suitable sizes preserved in juniper oil, and secure by tying three or four knots, finding the method about as quick as the use of shot, which are in some ways objectionable. While some may take exception to this, in my hands thus far, at least, nothing could be more satisfactory. Though hitherto content with interrupted suture alone, I have once or twice added to the déep sutures a continuous superficial one including little more than mucous membrane, beginning at the upper angle of the rent; and would recommend this in lacerations running high up the vaginal wall, as also in those with ragged edges. We cannot tell when a hæmorrhage and clot may distend the vagina and separate the line of union or force the lochia into the wound, thus endangering normal repair.

A single finger in the rectum is all that is needed to guide the needle, and as an aseptic precaution I use only the second finger for this purpose, reserving the forefinger and thumb for manipulations in the wound itself. (This holds equally in secondary operations.)

Fourthly, what rules shall guide us in advising secondary operations?

Here the conscientious specialist will find frequent oppor-

tunity to weigh many points before giving a decided opinion. The following is a case in point. A few days since, a lady came to me in great distress, saying: "Doctor, I'm sick and discouraged, and don't know what to do. One doctor says I'm torn, womb is displaced, and I must positively wear a support, and must be sewed up. Another physician, who has doctored our family for years, says there is no tear, no displacement, and that I must not wear any support. Now I've come to you as the third man to decide." *

As apparent causes for backache and profound nervous disturbance, examination revealed: patulous vaginal outlet, with commencing rectocele, retroversion, bilateral tear of cervix, with cicatricial tissue in the left.

While each case must be decided on its own merits, there are several indications of which we may mention:

(1.) Cicatricial tissue notably tender, as chief apparent cause for nervous irritability.

(2.) Rectocele and cystocele with retrodisplacement.

(3.) Loss of support as evidenced by—(a) Vaginal flat-us;—(b) Failure of posterior wall to meet the anterior under proper stimulus, *e. g.* pricking the labia.

Fifthly and finally, What one method is best for the majority of cases?

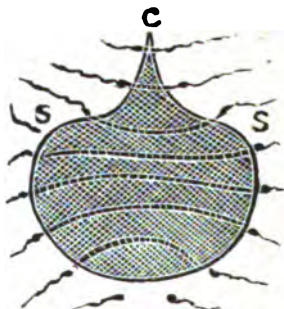
Could earlier operators have started with the elaborate demonstrations of anatomy by Savage or Ambrose Ranney,* and then agreed as to *just what occurs* in these injuries, much valuable time would have been saved, and much confusion avoided. To determine the real lesion is of first importance, and probably a definite settlement of this would ere long reduce the methods to two or three at most. Indeed, I am not sure that we are not rapidly approaching this already.

In the winter of 1884-5 Pawlik of Vienna taught his classes on the cadaver as follows:

* "Topographical Relations of the Female Pelvic Organs," 1883.

To determine the exact form of denudation, the perineum was incised in the middle line down to the sphincter. It was then cauterized with iron at red heat, the resulting scar assuming a shape in the outline something like the accompanying figure. It was held that the cicatrix in healing by granulation also took this form, and hence nothing could be more scientific than thus to denude when operating. There is a possible flaw here, in that living tissue, with retracting muscular fibres, may, and probably does, act differently. Otherwise, for *lacerations in the median line* this outline for denudation would seem purely rational.

The area to be denuded was marked out with the knife



C starts at crest of rectocele. The curved lines C S run to either side across the sulcus.

in this way: The usual points on the labia and crest of the rectocele were found by the tenacula. Beginning at the proper point in the posterior vaginal wall the knife marked the outline downwards and outwards across the sulcus and up on to the labium; the other side was completed in like manner. Forceps then seized the upper angle, and the mucous membrane was dissected by the knife, often as one piece. Though this method is doubtless suited to one form of injury, viz., simple laceration in the median line, it may not so readily commend itself for asymmetrical lesions.

It is strictly surgical and scientific first to discover in each individual case just what has happened, and then aim to restore what has here been lost. In all plastic work we

should allow ample scope, and never be bound by any stereotyped form. Yet there is an advantage in repeated use of the same process, provided that method fulfills the requirements of the case. The so-called new operation of Dr. Emmet has commended itself as being adapted to non-symmetrical injuries as well as the symmetrical. Though not the easiest one either to perform or explain, I have for a year or two past used it, or, perhaps, rather a combination of it with the one described above, thinking thus to get a more natural perineum. I am by no means sure that it is enough to secure in the sulcus the separated perineal fascia, but must regard equally the levator ani, which, according to Drs. Skene, Dudley, and perhaps as yet most authorities, is the more important part that sustains the pelvic floor. Certain lesions of which also, the former maintains, cannot be satisfactorily repaired.

The half-dozen cases in which during the past year I have employed this method, practically that of Dr. Emmet, present but little worthy of special mention. In one, however, my first attempt with this mode of operation, slight suppuration occurred, and I expected to lose the desired result. Examination a few months later, however, revealed, not an ideal perineum, nor indeed much of a perineal body, but, to my very agreeable surprise, a very excellent support in close relation with the anterior vaginal wall. So that I understand better what Dr. Emmet meant in saying that "he didn't care anything about the perineal body as a uterine support," or words of like import.

Another case presenting a recto-vaginal fistula through the upper edge of the sphincter, and also a bilateral laceration of the cervix, healed kindly, the three operations (cervix, fistula, and perineum) being performed at one sitting.

While Dr. Dudley * "has not found the operation satisfactory," my cases thus far, at least, have stood the test

*See article in *Am. Journal Obstetrics*, Dec., 1888.

applied; *i. e.*, the perineum, after being drawn backward, has returned promptly, the posterior vaginal wall lying in contact with and supporting the anterior. Furthermore, since most tears are not wholly central, but run sideways into one sulcus, thus assuming, as expressed by Dr. Southwick, the shape of the letter Y minus one limb (thus λ), the Emmet method would seem to admit of much wider application than that presented in Dr. Dudley's article.

HYGIENE OF THE EYES OF CHILDREN.

BY

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In this epoch of careful surveillance of sanitary arrangements with relation to the health of the general system, the demand for a consideration of the laws which govern the preservation in integrity of the organs of vision becomes a necessary corollary. Ought we to study air, water, food, sunlight, and all natural agencies with regard to avoiding their harmful influences on the human system, and yet withhold from our patients the ounce of prevention that, used during childhood, may save from blindness in old age or sooner? Is not the eye the most valuable to us of all senses? Addison says: "This little Member gives life to every other part about us; and I believe the story of the Argus implies no more, than that the Eye is in every part; that is to say, every other part would be mutilated were not its force represented by the Eye rather than even by itself."

Every day cases may be seen suffering from the neglect

of ocular hygiene ; a neglect proceeding from ignorance on the part of the laity ; a neglect that the general practitioner is, in a certain measure, responsible for, inasmuch as his opportunities are infinitely greater than those of the specialist for giving advice during the period of childhood. But, it will be pleaded, why need general practitioners pay any attention to special laws in regard to ocular hygiene ? Will not common-sense teach how to preserve the vision ? In return, it may be fairly asked, would we know anything exact in preventive medicine without a study of anatomy, physiology, pathology, and especially etiology ? Much more is it necessary to supplement those general laws of hygiene that can be applied to the preservation of the eyesight by adding a knowledge of the special laws of ocular hygiene determined by the immense progress realized by ophthalmology in its advancement to recognition as a distinct branch of medicine.

It will be the aim, then, of the following pages to give within the smallest possible space the laws governing the preservation of the organs of vision, with the hope that a clearer knowledge on the part of the general practitioner will lead to dispelling the ignorance, the inexperience, and the prejudices of the public upon these matters. First will be considered the portion of ocular hygiene concerning the earlier years of childhood, especially with reference to the precautions to be imposed in private life. As a preface to this, however, there is a little to be said in regard to the prophylaxis of heredity. Next the hygienic measures to be pursued with regard to subjects of errors of refraction will receive attention as a worthy prelude to the last pages, which will deal with the eyes during the educational period, including of course the hygiene of school-life.

HEREDITY.—We may divide this question into two parts: first, the influence of heredity on the conformation of the eye, and second, its influence on ocular affections of diathetical origin.

With regard to anomalies of form, Galezowski states that, according to statistics, 24 per cent. of all the congenital ocular deformations can be traced to hereditary influences. Otherwise, when not dependent on direct inheritance, certain congenital anomalies find their origin in arrests of development or in inflammations supervening during intra-uterine life.

Most frequently arrests of development take the form of colobomas. Thus we find sometimes an absence of a portion of the eyelid, of the iris (leaving one or more openings beside the pupil), or of the choroid. The arrest of development can affect the whole of the ocular globe so that this organ may remain rudimentary (microphthalmia) or altogether absent (anophthalmia). Congenital affections of the crystalline lens are also frequent. It may be absent (congenital aphakia) or be the seat of cataract. Atrophy of the optic nerve may also be congenital. Nystagmus has been said to be, in some cases, of hereditary origin, but the authenticity of this statement is to be doubted. Nystagmus certainly may arise as a consequence of hereditary congenital affections, but it is questionable if it can be considered as a hereditary disease on such a reason.

The direct bearing of what has been said is that children which bear the congenital anomalies spoken of are often the issue of parents, one or both, affected by an analogous disease, or by blindness consecutive to any ocular disease whatever—points for consideration in prophylaxis. Thus a parent, blind in consequence of ophthalmia neonatorum, may have a child affected by microphthalmus; or, again, atrophies of the eye and of the optic nerve, and congenital cataracts may be found among children, one of whose parents is affected by a cerebro-spinal disease. Bandon cites the case of a little girl of two years having a congenital cataract; her mother and her mother's father were both born with cataract.

The children of consanguineous marriages are also fre-

quently affected by congenital ocular affections. Fienzal imputes 38 per cent. of the cases of retinitis pigmentosa to this cause.

Prophylaxis.—Outside of advice with regard to the marriage of those affected with a hereditary ocular defect there is little to be done in a hygienic point of view of heredity. Marriages of the blind with the blind ought certainly to be protested against as a duty we owe to the State in our positions as guardians of the public health. The hygiene of vices of refraction is designed for a special chapter, and as such will receive attention farther on. So that it only remains to be said of these hereditary ocular defects that the advice of a specialist should be sought at an early date, if the family physician consider the correction of the condition outside his field of practice.

With regard to ocular affections arising from a hereditary diathesis, much can be done to avoid them if the existence of the dyscrasia be early recognized. Among these hereditary diathetical influences the most important with which we have to deal are syphilis and scrofulosis. At birth, and during the early years of infancy, the manifestations of these diatheses are most frequently absent; but, later, with progressive evolution of the organism, and as the child outgrows the tender care of very early years, becoming exposed to more of those relations to the exterior world that act in a deleterious manner, the irritations to which the system is constantly subjected favor the development of these ocular affections of diathetical nature. Thus a child which is born infected with hereditary syphilis or scrofulosis may present during the early period of life no more than certain peculiarities of physiognomy, but allow any condition of irritation of the general system to intervene (that may reflexly act upon the eyes), we can have developed a specific diffuse interstitial keratitis which reveals irrefutably the influence of heredity. Defective hygienic conditions in these cases, then,

call at once for removal, as the slightest irritation brought to bear upon the eyes threatens their integrity.

Prophylaxis.—The question of marriage in a prophylactic point of view has been merely touched upon with regard to the inheritance of ocular deformities, but here it becomes a problem of even deeper moment. When we remember that the health of many succeeding generations may depend upon our decision as to the marriage of scrofulous, and especially of syphilitic, persons, we feel that an immense responsibility rests upon us. Syphilitic individuals seldom realize their culpability in contracting marriage without the advice of a physician, and though our advice may be sometimes uncalled for, it still remains our plain duty to impress upon these people the future suffering which they entail upon their progeny. But as to how long a period should elapse from the last appearance of syphilitic lesions before marriage may safely be contracted, there can be no general rule applying to all cases; our advice must depend upon our judgment as to the condition of the patient, and as to the nature and site of the lesions last appearing. This we must of course leave to individual discernment and experience.

In cases of scrofulosis, they should be advised to oppose to the degenerate constitution one as free as possible from any hereditary taint. In this manner we occasionally see families regenerate themselves.

Lastly, when, in spite of all our advice, these individuals marry and have children, the function of the family physician is to exercise a rigorous surveillance from the child's birth during the period of nursing, after weaning, during dentition, and during the age of puberty, seeking to combat the hereditary influences by all general hygienic means, sanitary, educational, and gymnastic; for in no case do the hygienic relationships of the general system become more needful than in averting the noxious influence of hereditary taint from producing those ocular affections common to diathetic constitutions.

HYGIENE OF THE PERIOD OF INFANCY.

We will make some arbitrary divisions for convenience : First period of infancy, extending from birth to weaning ; Second period of infancy, extending from weaning to the age of two years ; Third period of infancy, from two to seven years ; and, lastly, will consider that period of childhood after seven years with regard to the relation of ocular hygiene to educational institutions.

FIRST PERIOD OF INFANCY.—*Ophthalmia Neonatorum*.—This is the first ocular affection to which a child is exposed in its entrance upon a separate existence, and not only is it the first, but it is most dangerous to the integrity of the eye. In proportion, then, as we realize its malignancy, we will redouble the vigor of our prophylactic measures.

The importance of this subject to the general practitioner cannot be insisted upon too much. True, it may be that in many years of private practice the family physician may perhaps meet only a few cases, but if through want of precaution on his part one of these cases becomes permanently blind, he is responsible for that life of darkness which might have been prevented. See to it then, that on your conscience there lies not such a life of blindness as Milton pictures :

“ O Dark, dark, dark, amid the blaze of Noon,
Irrevocably dark, total Eclipse
Without all hope of Day !
O first created Beam, and thou great Word,
Let there be Light, and Light was over all ;
Why am I thus bereav'd thy prime decree ? ”

A few words as to the origin of *ophthalmia neonatorum* will indicate the preventive measures. At the moment of birth the child's eyes are exposed to the danger of this purulent conjunctivitis by direct infection with the vaginal discharges of the mother. If the eyes are closed, these discharges are deposited on the borders of the lids and pene-

trate into the conjunctival cul-de-sac as soon as the eyes open. When, as in cases of prolonged labor, the eyes are open before the accouchement is terminated, the penetration of the infectious liquid is facilitated. The discharges of the mother are infectious, however, only when they contain the specific germs of this purulent conjunctivitis.

Our first duty, then, is to remove the specificity of the vaginal discharges. When we become aware during the later months of pregnancy that there exist leucorrhœal discharges, this state must be remedied, first, by attending to the general health, and, second, by suitable vaginal irrigations. These precautions as to vaginal cleanliness should be especially insisted on in the later days of pregnancy, in order that there be the greatest certainty of the absence of infectious discharges during labor.

As soon as the infant is ushered into the world, next after the precautions essential for the maintenance of life, it is necessary to proceed at once to the cleaning of the eyes. It is most often at the moment when the child opens its eyes for the first time that infection of the conjunctiva is produced. It has been shown by Peringer that the inoculation of the eyes of the new-born takes place at the end of two or three minutes after contact with the conjunctiva. The prompt washing of the eyes is, then, of greatest importance and should be undertaken before the general cleansing of the body. The water for this washing should be of gentle warmth; it should be prepared in a basin separate from that intended for the body of the infant; and the cleansing of the eyes should be performed with bits of clean soft linen rather than with a sponge. These bits of linen should be burned as the best means of disposing of any possible infection that they may retain. Above all, see that some meddling nurse does not add any such popular ingredients to the water as salt, milk, cold tea, etc. The liquid I prefer best is simple boiled water. There are those of course that will advise solutions of carbolic acid,

boracic acid, corrosive sublimate, etc. Cr  d  , author of that method of which we hear so much, goes even farther. He proposes cleansing with a solution of salicylic acid, following this immediately by the instillation of a drop of a collyrium of nitrate of silver of a strength of 2 per cent. To this procedure of Cr  d   as a *preventive method* I am opposed, because if there are no specific discharges present to infect the child's eyes, a solution of nitrate of silver in the proportion of two grains to one hundred drops of water may prove a dangerous remedy in the hands of the inexperienced, and if the inoculation has taken place, a solution of this strength is incapable of stopping the malady and preventing its appearance.

When in spite of all preventive means the inoculation has taken place and the disease declares itself, vigorous treatment becomes necessary, but a discussion of this has no place here. However, there are certain prophylactic means to be observed with regard to the eyes of others in the house. The malignancy of the infection must be impressed upon those about the child. The physician, and those who cleanse the eyes of the affected infant must take vigorous measures to avoid conveying the infectious discharges to the eyes of others. Finally the child should be isolated in a room by itself, and the most minute care must be observed that the linen and sponges are not used by others.

Once having averted the dangers of ophthalmia neonatorum, our attention is turned to the other different influences of the first period of infancy which can prove harmful to the future of the eyes.

As children learn the use of their limbs little by little, so ought they to learn the use of their eyes by slow degrees. The eyes of an infant are far more sensitive to light than those of an adult, for they are as yet but imperfectly developed. The eyebrows and eyelashes are short and thin. The eyelids allow much light to pass through them, because they are at birth almost transparent, and, most of all, the

iris is very imperfect, as it lacks that pigment which is taken on with the growth of the infant. The light, then, which is the natural stimulus of the eye, becomes its first enemy, and it is necessary never to admit too strong an illumination to the nursery until the child's eyes become accustomed to their new surroundings. The cradle must be turned away from the direct light of the window, or an opaque screen interposed, so that no strong rays fall at first upon the infant. Especially must the eyes be protected from the direct rays of artificial light.

Cold, moisture, and strong winds are likewise especial enemies of the eyes during the first months of life, and can produce, by their harmful impressions, catarrhal inflammations of the conjunctiva.

Cleanliness is also one of the important factors of prevention. Where children are playing about on the floor the eyes should have as careful cleansing as any other part. This should be done with very soft sponges or linen, and the irritating action of soap must be avoided.

SECOND PERIOD OF INFANCY.—From the time of weaning up to two years of age all the previously stated cautions should be in force, only that the need of cleanliness becomes greater than during the first period of infancy. The child now manifests interest in things about it; uses its arms and wishes to handle objects, consequently it may carry hurtful substances to its eyes. Dentition about this period becomes a time fraught with peril to the eyes in those of scrofulous constitution, and demands careful surveillance. Artificial light ought still to be prohibited, as the eyes of children at this age are yet wanting in the resistance necessary to avoid the harmful impressions of the vacillating and direct rays of light from artificial sources.

THIRD PERIOD OF INFANCY.—From two years onward the child commences a more active period of existence, and during the early part of this time the plays and toys require some supervision. During this time children are particu-

larly exposed to ocular traumatism, wounds, foreign bodies, burns, etc. In some cases such accidents are beyond the reach of prevention, but there is a certain proportion of these traumatisms that proceed from carelessness on the part of parents; they allow their children to play with sharp instruments, knives, scissors, pens, etc., and especially for out-door plays give them such harmful toys as the pistols with explosive caps that are so much in vogue with "Young America."

There are plenty of other amusements to interest children of this age, and we ought all to join in asking for laws to prevent the sale of these toys that now and then produce such sad accidents to children's eyes.

Toward the end of this period it will be asked, is it now time for the child to begin the systematic use of the eyes? Now I am not one of those who advise putting off the beginning of study until eight to ten years of age, nor do I, on the other hand, admire the forcing-system of education. Much depends on the condition of the eyes, on the presence or absence of errors of refraction. Ordinarily there can be taught the child, before six years of age, much in the way of observation, but without any prolonged use of the eyes. After six, seven, or eight years the exercises of reading and writing can be a little more prolonged. From seven to ten years the time of study may be lengthened, to three or four hours each day; from ten to thirteen years five to six hours will be sufficient. These periods of study it is always important to interrupt by intervals of recreation for the purpose of avoiding prolonged work at near vision. But there remains much that is dependent, as before mentioned, on the refractive conditions of the eye, and to a full understanding of these states short explanations must be entered on before going further into the hygiene of the eyes during the educational period.

(To be continued.)

ECLAMPSIA GRAVIDARUM.

BY

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Mrs. B., age twenty-four; brunette, extremely anæmic, of scrofulous diathesis. On the 18th of last October she came to my office to engage me to attend her at time of parturition. She was at this time a primipara six and one half months advanced in pregnancy.

On inquiry I learned that since the beginning of gestation her general health had been better than usual; she had no nausea, appetite regular and good. By adhering to a simple nutritious diet, and using fruit freely, she had during gestation kept her stomach and bowels in excellent condition, though prior to this she had been of a constipated habit. She was very active, cheerful, and very hopeful. The only symptom she had to mention which in the least disturbed her was œdema of the feet and ankles.

I examined the urine and found a small quantity of albumen, for which I prescribed arsenicum alb. 3x.

November 9, the albumen has increased; the œdema greater; hands and face somewhat œdematous in mornings. Still she says she feels well, sleeps quite well, and has no headache.

December 1, the albumen greatly increased.

December 5.—At 4 o'clock in the morning I was hastily summoned to see this patient. I learned that the day before she complained of a headache, which grew worse as the day advanced. Toward evening she commenced to vomit, and her mind wandered. When called to her, I found her moaning, pressing her hands over the left temporal region, talking incoherently. The skin was hot and dry, pulse

bounding, hard, and irregular, and occasional vomiting. I gave aconite and belladonna, put ice-cloths on her head. Odor of urine could be detected through the skin. On examination I found no signs that labor had begun. The patient was at this time at close of eighth month of gestation.

At 2:30 P.M. she had a convulsion, which lasted about three minutes, followed by coma; and this in turn followed by mania, for which I gave chloroform and hypodermic injections of morphia.

From the gravity of the case I was convinced that nothing but speedy delivery could save the patient. Between 2:30 and 11 P.M. the patient had four severe convulsions, pulse being very irregular. Dilatation was accomplished by manual dilatation, and the use of Barnes's dilators. Gelsemium was given, and there were no convulsions after exhibition of this remedy, although the mania was pronounced.

In my judgment, exemption from spasms might be attributed to action of gelsemium, combined with the progress of labor. Chloroform was used during labor, and at 4:20 A.M., December 6, just twenty-four hours after I was first called to this case, the dilatation being sufficient, the patient was completely anæsthetized, the forceps applied and the child delivered,—a girl weighing four and one-half pounds. It looked like a hopeless subject, but the heart was started into a feeble action by cutting the cord and allowing a little blood to run out, and a superficial respiration was started. Both soon stopped, however. By repeating with energy our first efforts, we again succeeded in starting up the life forces. At the end of half an hour, during which time the heart ceased beating twice, and the respiration ceased thrice, we were rewarded by continuous action on the part of both heart and lungs, although feeble at first. The little one was wrapped in hot cotton batting sprinkled with brandy and placed in the arms of an assistant, who watched its every breath for two hours.

Cases of infection also may come from the digestive tract, caused by injuries, and finally cryptogenetic forms.

As regards the antiseptic therapeutic measures, Epstein properly emphasizes first, principally, prophylaxis, and secondly asepsis. As to the navel Epstein has tried all newly proposed methods of bandaging, he having rejected the Lister's bandage, simple occlusive bandages with salicylic iodoform cotton and the corrosive sublimate cotton bandage; the occlusive bandage of Dahrn, the bandages soaked in carbolized oil, solutions of salicylic, boracic acid and thymol, as well as bandages soaked in glycerine.

Dry bandages, with powdered boracic acid, salicylic acid, starch and iodoform, are somewhat better; but the normal course could not be guaranteed. What is to be desired is the rapid mummification of the remainder of the umbilical cord; and it may be attained without antiseptics by the most careful disinfection of all hands, utensils, and especially of the clothing, coming in contact with it.

Again, the avoidance of any mechanical irritation or traction, which often leads to the formation of umbilical hernia. Epstein advises the stump of the umbilical cord to be left 3 to 4 cm. long, and instead of the ordinary long band, which often gets out of place, he uses a short linen bandage, going but once around the body and fastened by four tapes, and provided with a tobacco-pouch-like sac for the reception of the stump of the cord.

This bandage protects the navel from traction, permits a rapid mummification, and has been used by Epstein for two years with good results. He further advises the addition of a small amount of permanganate of potassium to the bath of the new-born. In avoidance of infection through the buccal cavity Epstein warns against washing it out, as seems necessary in diseases of the same. In the treatment also of asphyctic children the greatest caution is necessary.

Especially in conjunctival blennorrhœa is the active pro-

cedure of Credé useful, and much better than an attempted prophylaxis by means of washing out the vagina; yet he would not desire to see Credé's method introduced among midwives.

Feeding with sterilized milk he regards as a great step forward, but does not find therein a solution of the question of the artificial feeding of children.

INFANTILE LEUCORRHŒA AND A CASE OF IN- VERTED UTERUS IN INFANCY.

BY

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It is now some fifteen years since we had in Wickville Center, on the south side of Long Island, a large number of cases of infantile leucorrhœa. Two of them came under my care, following scarlet fever, or rather aborted scarlet fever. This I have contended for years as being possible. Let me take a few lines to explain my meaning.

I was called to attend a brother of these girls, who was sick with scarlet fever. The girls had not as yet shown any symptoms of this disease, and to prevent their having it I put them under *apis m.* 3 dec. dil., three times daily. The oldest was very sick for a few days, but no rash was perceptible, and from this sickness I inferred that the scarlet fever poison was at work in the system. The *apis m.* fought and conquered the poison, and saved the girl from the disease. While the fight was on, she suffered for three days, but there was no scarlet fever in either of them, the oldest eight years old, and the youngest five years old.

Some weeks after, their mother, an intelligent lady, a sea-captain's wife, showed me the girls' linen stained with a greenish leucorrhœa, which was very acrid. The oldest girl was menstruating as regularly as an adult, but this had no apparent influence on her general health, which was considered good, and she was a very fine, large child for her age. This leucorrhœa did not trouble any one but the mother; the children only complained of intense itching in the parts. In the youngest child the leucorrhœa was the greenest, but both were cured by *sepia* 6th, given three times daily for a few weeks.

Dr. Rushmore, of Hempstead, to whom I mentioned this case, told me that he had a case in hand that had suffered in the same way; at first with an acrid leucorrhœa, but now there was some tumor protruding from the lips of the vulva; and the next morning there was to be a consultation of physicians, and he invited me to be present.

The following morning I met Drs. Rushmore, Frost, and Beals. I was late and the examination was over; and they had placed a ligature round the protruding part. As there could be no examination *per vaginam*, I asked if they had examined *per rectum*; they had not thought to do so, but gave me permission. This gave the little one, some five years of age, much pain, and I felt that I changed countenance. They noticed it, and asked what was the matter. I answered that they could not know what they were about, as there was a tumor back of the protruding mass as large as the child's head. Dr. Frost at once examined, and found it was as I had reported; but what was it? I determined from the fibrous character that I should call it an inverted womb; but have you ever seen one? was asked. I said no; and I did not think any one else had. I advised operation by the Cæsarean process, now called laparotomy, but as that could not be performed, there was nothing could be done but to wait for nature, and then by post-mortem examination to determine.

It was not until six months had passed that I was again called. The same physicians were present, and Dr. Pray from the Woman's Hospital. Dr. Frost commenced, and Dr. Pray and I completed, the autopsy.

The body was greatly emaciated ; countenance very haggard, and a perfect living skeleton except that the body was very greatly swollen. When the body was opened by a cut down the median line, and then across by the liver and spleen, to lay back the abdominal wall as far as possible, we found the body completely full of a fine yellow network growing upwards from the mass that was protruding from the vagina ; growing upwards, until every crevice had been filled between the intestines, kidneys, and liver, and it had perforated also the diaphragm and penetrated the chest ; this latter we did not open, and so we do not know how much further this growth extended. It was long and yellow, like a woman's blonde hair, or like the appearance of dough when in sponge and poured out, or honeycomb when drawn out. We found the liver filled with cancer. The ovaries and kidneys were found healthy, but we found no uterus in the place where it ought to have been. It was inverted and protruding, in about the same condition I had diagnosed when it was ligatured six months before.

It was then drawn inward and taken away with the large lobe of the liver for microscopical examination, but no report was made.

I close by asking, what was the cause of the acrid green leucorrhœa? Was it caused by the débris of the scarlet fever? And would my two girls have suffered and died, as this child did, had she not been under the care of a homœopathist? Sepia no doubt prevented the slipping down of the uterus, and prevented the inversion.

The child that died lived through an attack of scarlet fever, when two others in the family died under old-school treatment, for it was not until the protruding mass was in sight that she was placed under Dr. Rushmore's care.

Another question : I am sure the protruding mass from the vagina was an inverted womb (for since then I have had two cases of inverted wombs where I could feel and examine the inside of that organ). What was it that caused the growth from the cervix of this yellow streaming mass, like coarse yellow hair ?

● EDITOR'S TABLE. ●

During the past year, Apostoli's method has received a great deal of criticism, and has even been looked upon with suspicion as to the veracity of the originator.

Dr. Laphorn Smith seems to have made very fair and unprejudiced investigations as to the merits and demerits of the use of electricity in gynæcology. His opinion is worthy of consideration. He began the use of Apostoli's method about the month of October, 1887, and has had an almost daily experience with it ever since. "Some nine months having elapsed since the termination of the year, I am perhaps justified," he says, "in now laying my experience, in this most interesting department of gynæcology, before the profession. Before I began, I had a somewhat too exalted opinion as to its value. This was followed by the usual reaction, and, being brought to face a number of cases noted for their difficulty, I became a little discouraged. Later on, as the benefits of the treatment began to slowly but surely mount up with the increasing number of cases, a firm and lasting belief in its capabilities has been acquired. I mention these three phases of opinion of the treatment, because I see around me evidences that my confrères who are trying it are going through the same stages."

* *

Venesection as the remedy for puerperal eclampsia was discussed at a recent meeting of the Chicago Gynæcological Society,

and with one exception each speaker gave unqualified endorsement of this method, and the members present included a goodly number of the leading practitioners of the old school.

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The one exception, however, stands out so prominently that to some portions of his remarks is due serious attention. Says Dr. Jaggard, in substance, there are three good reasons why we should not bleed in urinemic eclampsia. First, because the amount of excrementitious material that can be eliminated by bleeding is comparatively trivial. Blood pressure cannot be depressed for any length of time unless the patient be dangerously exsanguinated. The indication for bleeding in eclampsia is not stronger than in the convulsions of Bright's disease, and no one would bleed in the latter affection.

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Experience—the best teacher—demonstrates that better results now obtain when venesection is not practiced. Witness these statements: In the Vienna clinics, where the results obtained are better than anywhere else, blood-letting has been completely discarded. Winckel, under similar conditions, had ninety-two cases and seven deaths. In Schroeder's clinic (Berlin) it is no longer practiced. If, then, blood-letting is unphilosophical, and it is opposed by clinical experience, upon what ground should it be tolerated? If bleeding then must be, let us bleed the woman into her own veins by the use of *veratrum viride*.

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If not bleeding, what then? Dr. Jaggard has treated thirty cases, and this is his plan: "In eclampsia during pregnancy, first, after the insertion of the gag and the protection of the patient's body by pillows, the indication is to control the convulsions by profound narcosis. The choice of anæsthetics is not so important as that the narcosis be deep and continued, and chloroform is by far the best agent to control seizures, while the narcosis can best be maintained by chloral *per rectum*.

"Second. Evacuate the uterus as rapidly as may be consistent with safety to mother and child. Convulsions cease when labor

terminates in about one-third of all cases ; in an equal portion they grow less frequent and severe.

" Early in the first stage of labor, before effacement of the cervix and dilatation of the os, puncture the membranes as the best means to accelerate labor. The escape of the liquor amnii is not infrequently followed by an abatement of the convulsions. Later in the first stage, after effacement of the cervix digital dilatation of the os externum is often indicated. Delivery may be completed by forceps or version and extraction, according to the conditions.

" Third. Eliminate the retained excrementitious products of the urine by diaphoresis, purgation, and diuresis. The hot pack is probably the best means. The vapor bath by means of the alcohol lamp is easily exhibited. Pilocarpine must be used if at all with extraordinary caution. Deep coma, weak heart, and beginning œdema of the lungs are absolute contra-indications.

* * *

Posture after completion of labor is a matter worthy of study, though the subject is by no means a new one. More than a hundred years ago, Charles White, of Manchester, a Fellow of the Royal Society, wrote on the management of pregnant and lying-in women, and in the chapter on the prevention of puerperal fever there occur one or two passages on this subject of posture, which are striking : " In a few hours after delivery, as soon as the patient has had a little rest, she should sit up in bed with a bedgown thrown over her shoulders. If she propose to suckle the child, it should now be laid to her breast, whether there be signs of milk or no." And, again : " The patient should lie very high with her head and shoulders, and should sit up in bed many times in a day, especially when she takes her food and as often as she suckles her child, and should kneel whenever she has occasion to make water, which should often be done. This frequent upright position is of the utmost consequence and cannot be too much enforced. It prevents the lochia from stagnating, the stools and urine from being too long retained, and promotes the contraction of the uterus, together with that of the abdominal muscles."

How contrary is all this to what is now usually taught ! Yet the plan here advocated is merely an application to midwifery practice of the great antiseptic principle of drainage.

walls in such a way as to relieve the strain upon the over-distended tissues.

* *

From the fatal case in Dr. Lusk's practice* there are indicated certain measures to be adopted when a rupture of the uterus has taken place. The first indication for treatment is the speedy removal of the child. In selecting the manner for accomplishing this the important consideration to be kept in view is that it shall to the least possible extent increase the dimensions of the rent. In general terms Dr. Lusk states that with an undilated cervix, or in cases of extreme pelvic contraction, or after the passage of the head and arms through the rupture, and in all cases where the child passes entirely into the abdominal cavity, laparotomy is the more conservative measure. There is not only less shock, but the opening of the abdomen enables the operator to remove effused blood and amniotic fluid from the peritoneal cavity.

* *

The employment of the suture to close the uterine wound, in view of recent Cæsarean successes, seems reasonable ; but it is to be borne in mind that with ragged borders infiltrated with blood, with the peritoneum stripped off, and sometimes with air infiltrated into the subperitoneal connective tissue, the conditions are in no way comparable to those which exist in Cæsarean section. Porro's operation promises better results.

When the child can be removed by the natural passages, without increasing the extent of the rupture, and when the latter is confined to the lower segment, laparotomy is of doubtful value. In many such cases recovery, as far as life is concerned, has been secured by the employment of antiseptic irrigation and filling the gap with antiseptic gauze. At the same time drainage should be secured, and carefully graduated compression should aid the uterus to secure firm contraction.

* *

In order to afford students every advantage in the study of obstetrics the *Clinique d'accouchements* in Paris has been connected

* *The Journal of the American Medical Association*, vol. xii., no. 25.

with the *Faculté de Médecine* by means of electric wires. In this way, every time that a simple or complicated accouchement or an obstetrical operation is expected, the fact is announced to the students by a little flag, which has different colors for the different cases.

* * *

We are not far behind in America, in new ideas, however, for we read in a late exchange that it is proposed to press the phonograph into service by having recorded the various kinds of coughs characteristic of the different lung and throat diseases. In this way it would be possible for the lecturer on pædology to reproduce before the class the characteristics of whooping-cough and of croup.

* * *

Professor August Breizky, of Vienna, one of the best known Austrian gynæcologists, is dead. Prof. Breizky occupied during his life many important positions. He was named as the professor of obstetrics and gynæcology at Salzburg (1866-67), at Berne (1867-74), at Prague (1874), and afterwards came to occupy the chair in Faculty of Medicine of the University of Vienna. In the midst of all these duties he was ever an active worker, and we owe to him many important memoirs.

● GYNECIC ETCHINGS. ●

—In 95 cases out of 100 women examined immediately after labor, Dr. Ouvard found vulvular traumatism.

—Among these 100 women delivered at full term there were in round numbers the following proportion of accidents :

Vulva intact.....	5 per cent.
Perineum alone ruptured.....	15 "
Latero-superior parts only ruptured.....	30 "
Rupture of all the vulvular circumference	50 "

—To reflect on 95 per cent. of vulvular wounds among our parturient women, and this in tissues containing a rich layer of

lymphatics (which by their superficial situation are eminently adopted for absorption) would lead one to see how important, for prevention of septicæmia, is a rigorous vulvular *asepsis*; a condition sometimes forgotten among those physicians who needlessly fatigue a woman with repeated vaginal (or even intra-uterine) injections, when vulvular cleanliness would be sufficient.

—Hysteria is not essentially a womb disease—not truly *hysteria*. It may occur before the womb is potent, and after its potency is past; and it occurs in men. But may be said to have alliance with the womb, or with the genital organs generally, because it is far more common and more severe in women than in men, and it prevails chiefly during the period of activity of the genital system of organs.

—Therefore we may say that it is a gynæcological disease in the sense that it specially attaches itself to the generative system, because the genital system, more than any other, exerts an emotional power over the individual—a power over morals and an influence over social questions and social relations. Though the womb cannot travel through the body and produce diseases, yet its influence in the hysterical state may manifest itself through the ganglionic system, by which it is so intimately connected with the cerebro-spinal nervous centers, and affect any part of the body, mimicking more or less perfectly diseases of various sorts, or even producing novel combinations of symptoms.

—The name “hysteria” is much and often objected to, because the Greek root of it is the “Womb” (*ὑστέρα*), but we have seen its intimate connection with gynæcology. Besides, it is not in any one’s power to make the profession give up its use or adopt another; as in some other instances, the word will remain until scientific progress presents clearer analyses of the pathology of this hydra-headed disease, and adjusts to it a designation in accordance with the accepted nomenclature of disease.

—In connection with hysteria there is brought to mind some comparisons of tarentula with its concordant remedies in this disease, which the late Dr. E. A. Farrington elaborated in his lectures.* *Lycosa tarentula* is one of the most useful remedies in

* Compare Farrington’s “Clinical Materia Medica.”

hysterical symptoms reflex from the uterus, particularly where there is marked spinal irritation and great excitability of the peripheral nerve-endings. "The patient keeps the hands in constant motion, trying to work off this over-excitability. The playing of a lively piece of music excites her, and starts her to acting like one crazy. When there are no observers, she has no hysterical attacks. As soon as attention is directed to her she begins to twitch, etc. When she has headache, it is better from boring the head into the pillow. Rubbing seems to relieve."

— In comparison with *lycosa tarentula* in hysterical states *ignatia*, though agreeing in some respects, has a well-defined individuality of its own. Like *tarentula*, *ignatia* is preëminently a spinal remedy: all the senses are excited to an intensified impassionability; there is incoördination of function and contradictory action. But all through the hysteria of *ignatia* there is a hidden tinge of melancholy which *tarentula* has not. The patient is extremely susceptible to emotional influences. Fear and grief affect her seriously; the least contradiction offends; she is readily chagrined, and so is often reduced to grief and tears by the slightest causes. Her mental states, however, are not usually exhibited in violence and rage. On the contrary, she nurses her troubles in seclusion and silence, and broods over them until they prey upon her whole system. She grows more and more nervous, and, at the same time, more and more weakened. The heart beats nervously, with variable pulse; she sighs heavily and deeply; suffers from goneness at the stomach, with qualmsiness and flat taste in the mouth; feeling of a lump in the throat swelling sympathetically with the intensity of her mental disturbances. Sleeplessness or violent startings of the limbs. Grief, fright, disappointed love, or some other similar causes may develop hysteric paroxysms. The moods change with wonderful rapidity; now she laughs and jokes, then quickly bursts into tears. Her manner becomes hurried, so that everything is performed hastily, and hence imperfectly and awkwardly. She is afflicted with intense headaches. These are characterized by a predominance of pressure; the pain goes to the eye, which feels as if pressed out; or to the root of the nose; or, again, it is confined to one small spot, like a nail pressing on the bone (*clavus*

hystericus). At the height of the paroxysm she becomes chilly and restless, and often describes a peculiar perversion of vision ; she sees fiery zigzags when looking out of the line of vision (theridion). Finally, a profuse flow of colorless urine terminates the attack. (Several other remedies have this last-named symptom, headache relieved by copious urination. They are : aconite, gelsemium, silicea, and veratrum album.)

—We have also some masterly comparisons by Farrington of a number of other remedies that approach closely in their action to *lycosa tarentula* ; among these are *kali bromatum*, *crocus*, *actea racemosa*, *causticum*, *platina*, *palladium*, *moschus*, and a whole list of drugs of minor importance. Of all these he gives us *actea racemosa* as resembling *tarentula* most closely in producing sleeplessness, restlessness, trembling, and fear of death ; and, too, these evidences of nervousness are often in *actea*, as in *tarentula*, reflex from uterine affections. The former has : After going to bed, jerking, commencing on the side on which she is lying, compelling change of position, nervous shuddering and nervous chills. Mentally the two drugs differ. *Actea* causes nervousness ; she feels as if the top of the head would fly off ; delirium with jumping from subject to subject ; sees strange objects ; great apprehensiveness as a concomitant of uterine irritation ; pains darting into the eyeball, through to the occiput. Feels grieved, troubled, with sighing ; next day tremulous joy, mirth, and playfulness.

—Proximity to a menstrual period, presence of chronic peritonitis, ovaritis, or salpingitis, or even an intense degree of engorgement of the periuterine reservoirs and ovarian bulb, without inflammatory exudation, all tend to render intra-uterine medication dangerous, because tending to render periuterine hyperæmia excessive.

—The accoucheur should never, in his exultation at having successfully terminated a difficult case of labor, lose sight of the fact that, while the patient may forget that he saved her life, she can never forget or forgive his making light of a laceration of the cervix or perineum, for which she must undergo a subsequent operation.

—Dr. Lute von Wedekind reports in *Il Pisani*, 1888, that pres-

sure on the supra-orbital sulci, with gradually increasing force, affords a practical means of correct diagnosis in ascertaining whether coma depends on alcohol, hysteria, or other causes. In hysterical epilepsy and in hysterical convulsions this method has always cut the fits short in twenty-four to thirty seconds.

● GOLDEN GRAINS. ●

—In children, when it is desirable to bring the tonsils into view, or to have them more easily within reach for the purpose of examination, application, and operation, external pressure over the organ will greatly facilitate the endeavor.

—Lachesis may be used with success in puerperal metritis, especially when the lochial discharge is fetid. From the first the abdomen will be sensitive to the least pressure. The face is purple, and later the patient becomes unconscious.

—The reaction against the indiscriminate spaying of women is bearing good fruit. At a joint meeting of the Neurological and Gynæcological sections of the New York Academy of Medicine, the question of the ovarian origin of various neuroses was discussed. There was a general consensus of opinion that the influence of the ovaries in the production of epilepsy, chorea, etc., has been exaggerated; that the nervous system is often primarily at fault, even when distinct ovarian disease co-exists, and that their removal in such cases does not materially benefit the nervous trouble.

—A child, five years of age, repeated in speaking the first syllable of the first word three or four times; after overcoming this obstacle he continued to speak without difficulty. If, after a pause, he began to speak again, he again stammered. Worm symptoms were present. *Spigelia* 6x, given morning and evening, cured in a few days. In this case the fault of pronunciation depends on a peripheric irritation proceeding from the pres-

ence of worms in the intestines. It is no proof, then, of the action of spigelia on the motor centers of speech.

—Few diseases prove so vexatious or intractable as chronic cystitis in the female. The lesions or morbid causes giving rise to cystitis are numerous, whether it be the acute or chronic form. Each case must, then, have separate consideration. The arrangement of the muscular coat of the bladder is such as to give it a wonderful immunity against the ordinary accidents and conditions which occur within the viscus itself. This fact should make us remember that the symptoms present in a cystitis are often aggravated, intensified, by a co-existent lesion or morbid process, also within the pelvis, but at a distance from the part seemingly most affected. Thus, anal and rectal inflammation are often aggravating circumstances in cystitis, and may even be the cause of a bladder trouble.

—A little girl of three years, scrofulous, began suddenly to stammer, especially at the commencement of a phrase, and principally for sounds formed in the throat, the palate, and the tongue. The words sounded as if the child had something in her mouth, and the organs of speech appeared paralyzed and stiff. After giving many remedies without success, the child was cured by three doses of platina 30.—DR. WOSSA (*Revue Hom Belge*).

—Palladium, platina, and lilium tigrinum are three remedies often associated in the mind of the gynæcologist by the resemblance of their mental symptoms; they all have irritability, "easily angered," and "things don't go right." But the palladium patient is not haughty, she is only proud, and has such a fondness for the good opinion of others that she is continually getting slighted. The platina patient is distinguished by her haughty and egotistical manner, and, finally, the lilium patient is neither proud nor haughty, she has only a nervous irritability.

—Cantharis is often indicated in gravel in children, when they have irritation at the neck of the bladder, and extension of the local irritability to the penis, inducing an almost constant pulling at that organ.

—In cramps of the calves of the legs, when cuprum fails to bring about beneficial results, think of strontiana carb. 3x, especially when associated with cold feet ; secale cornu. 2x, when complicated with uterine difficulties ; ammonium mur. 1x, in pregnant women.

—Dr. Marcoli calls attention to the occurrence of nephritis as a sequel of whooping-cough. In 1887, among the children who suffered from the disease the attack was followed in two by nephritis, which proved fatal in one of them. The necropsy left no doubt as to the existence of nephritis. In 1888, among thirty-five cases of whooping-cough, Dr. Marcoli met with nephritis in four ; two of these died, and in one of them a post-mortem examination was made. The kidneys showed the microscopic changes of a severe parenchymatous nephritis.

—Theridion is not widely known as a remedy for hysteria, but within late years a number of cases have yielded to its influence, particularly hysteria in connection with spinal irritation. The theridion patient is sensitive to light, faints after every exertion, and has weakness, trembling, chilliness, and anxiety. She is restless, must busy herself about something, though nothing gives her pleasure. The strong distinctive characteristics are found in the great sensitiveness to noise and the great sensitiveness between the vertebræ. So great is this hyperæsthetic condition of the spinal column that the patient sits sideways in her chair to avoid the pressure of the back of the chair against the spine.

—In a recent number of the *Medical Press* Dr. Greene records two cases of sickness of pregnancy treated successfully with common salt. In the first case the salt was given in five-grain doses in one ounce of chloroform water. The sickness lessened after the first dose and ceased entirely when six doses had been given. The medicine was continued three times a day until the end of gestation. In the second case the same result was obtained. The faction of the salt in these cases may have been due to its antacid properties ; in both cases the secretions were very acid, but soda, potash, etc., had no good effect.

—In the constipation of young babes the following is recommended. Add one tablespoonful of fine oatmeal (steam-cooked)

to one pint of cold water. Stir well and strain off the water. Boil the water thus strained off until it is reduced to about one-half in quantity. When ready for use add to this one-half to two-thirds milk, sweeten a little, and add a pinch of salt. Should be prepared fresh every morning and kept on ice.

—Kreosote is, in children of all ages, as well as in adults, the chief remedy for odontalgia when it is caused by caries of the teeth. When dentition is so badly performed as to become a disease, comprising general inanition and cachexia with degeneration of the teeth themselves, especially when the child is constipated, kreosote is the specific remedy.—*N. A. Jour. of Hom.*

—In the bronchitis of very small children arsenicum album is a frequently indicated remedy. The symptoms for which arsenicum proves curative are, frequent sneezing, restlessness, wheezing respiration, and rattling in the chest. The child wakes suddenly from sleep and breathes with difficulty until held in an erect position—for instance, over the nurse's shoulder. The breathing is choked and rattling during the most part of the day, better in the evening, and then worse after midnight, about two A.M.

—Dr. Percy Wilde, of Bath, believes the silicate of soda to be a more powerful stimulant to adenoid gland tissue than any other drug, and regards it as acting primarily on the tissue. He claims great curative results from the use of this preparation of soda in tumors composed of lymphatic glands. Thus he says (*Monthly Hom. Review*): "Where there is a large tumor composed of a bunch of lymphatic glands, and no immediate symptoms follow its use, the first appreciable sign will be that the apparently solid tumor will become softer, so that the individual glands composing it can be made out, and the subsequent result will be the gradual diminution of the size of the glands until the whole disappear. The soft bunch of cervical glands which form a tumor of considerable size in anæmic single women will yield much more promptly than the single indurated gland, especially when that gland is situated in the breast. It is these enlarged glands in the breast which have given me the most trouble. When not malignant they are always curable, but the difficulty I have found is to decide upon the right remedy at the outset. If it is a lactiferous gland

the best results are obtained from *phytolacca* and *conium*, followed by *hydrastis*. If the enlargement has gone beyond the stage of *hydrastis*, and is indurated, calcium sulphate is most valuable, whereas when the enlargement is in an ordinary lymphatic gland, silicate of soda appears to be the best remedy."

—In children, the angina of both measles and scarlet fever has a special tendency to extend by continuity of surface into the nasal passages and into the eustachian tubes; if this tendency is neglected, permanent impairment of hearing, in consequence of adhesions, rigidity, and even destruction, of the parts of the transmitting mechanism, is an almost certain result.

—*Bufo rana* seems to cure blisters on the skin, such blisters as are called *bullæ*. These rupture, leaving a raw surface from which there oozes an ichorous fluid. Reasoning from this and from the power of the drug to produce convulsions, a woman was successfully treated with *bufo*, the indications being spasms, with suppurating blisters on the skin, in the throat, and in the vagina.

—Young children are very susceptible to gaseous or toxic emanations or to bad odors. An odor or emanation which is scarcely perceived by adults may influence their nervous system very unfavorably. Thus harmful gases, whether incapable of entering in the blood by respiratory processes, as carbonic acid gas, or, on the other hand, true destroyers of the blood corpuscles, like carbon monoxide, if found in very small quantity in the atmosphere surrounding a very young infant, can compromise its health gravely and rapidly, without the parents forming a suspicion of the cause,⁷ for the reason that these gases may exist in too feeble quantities to influence persons of greater vigor.

—When the catarrhal symptoms of whooping-cough are slight and the whoop is marked; when there is a hard cough, with well-marked laryngeal spasms, with cough worse at night and after lying down, *mephitis putorius* has been found to be the curative agent.

—From some investigations on "gout in the female" Dr. Mabboux concludes : 1. That gout can effect the genital apparatus of the female ; 2. that there is an acute genital gout and a chronic gen-

ital gout ; 3. That attacks of acute genital gout in the female are distinguished by passing uterine congestion in the intervals between menstrual periods, by states of hemorrhagic flow, by dysmenorrhœa, simple or membranous, and by vagino-uterine neuralgias ; 4. That repeated attacks of acute genital gout cause a chronic metritis, with all its symptoms of uterine and peri-uterine engorgement.

—Colchicum resembles podophyllum in the reflex cerebral irritations of children during dentition ; it has, like podophyllum, convulsions, with variegated, slimy stools, and rolling of the head from side to side, but may be distinguished from the mandrake by (extreme prostration, coma, hot abdomen and cold extremities, marked tympany, and white flakes and shreds in the stools.

—The common *pot de chambre* may sometimes be at fault in a prolapsus uteri following the lying-in period. To allow a puerperal woman, with the heavy uterus, to strain in a squatting position on the low chamber in ordinary use is a direct invitation to descent of the pelvic organs. In this position, considering the vagina as a hernial canal, the uterus while yet in the period of subinvolution has little to prevent its descent. Either forbid the use of the low chamber during the puerperium (better for woman, were it banished entirely), or allow it to be used only on a box or stool sufficient to bring it to the height of an ordinary water-closet seat.

—Glonoin is sometimes an admirable remedy for puerperal convulsions, the congestive form of eclampsia, that form which is announced by rush of blood to the head, especially if there is albuminuria. The face is bright red and puffed, the pulse full and hard ; the patient froths at the mouth, she is unconscious, The hands are clenched, the thumbs being in the palms of the hands. Glonoin has also proved useful in disturbances of the climacteric ; here it is curative where there is cessation of flow, with intense fullness of the head at every menstrual period. It is even useful in young women affected by congestion to the head from suppressed menses.

ORIGINAL TRANSLATIONS.

The Editor is assisted in this department by Dr. S. Lilienthal, San Francisco, Dr. H. H. Crippen, San Diego, Cal., and Drs. Pick and Pritchard, Boston.

HOT INJECTIONS OF 40° R. POST-PARTUM. BY DR. DEIPSER, MEININGEN.—Many gynæcologists believe that in natural labors no interference ought to be the rule, and hot injections can only be indicated where there is a suspicion of infection, but after a labor we have no objective symptom hinting to infection, and Deipser urges therefore the prevention of infection, and advises after the removal of the placenta, and once during consecutive six days, an injection of one liter 40° R. hot water, the pelvis raised and the upper part of the body lowered. The temperature of such water is destructive to bacteria, and by the injection blood coagula and foreign substances are most easily removed. Water at 40° R. is a powerful stimulus for the contraction of the uterus, and has been used before for post-partum hæmorrhages in consequence of relaxation of the uterus or for too weak pains. Though there may be none of these indications, a powerful contraction is certainly no mistake whenever infection may be possible, and secale cornutum is often prescribed in the beginning of puerperal fever. The method is without danger, and in consequence of the position held by the puerpera a part of the hot water passes the open cervix and washes out the uterine cavity; the open bloodvessels are stimulated by the hot stream, and the contraction of the uterus closes them firmly and all placenta remnants, so much to be dreaded, are thus removed. Though the uterus bears well such hot injections, it is advisable to lubricate the external genitals with vaseline, lanoline, or some such substance, and to interrupt several times the stream.—*Centralbl. f. Gynæc.*, 22, '89.

THE INDICATIONS AND PROGNOSIS OF THE OPERATIVE TREATMENT OF ABDOMINAL TUMORS, BASED UPON 285 LAPAROTOMIES. ORVOSI HETILAP 48, 1888. From an interesting lecture held by W. Tauffer, of Budapest, at the meeting of the Hungarian "Naturforscher" at Gátrafüred, we extract the following :

Every movable ovarian tumor diagnosed with certainty and at least the size of a fist is the sooner removed the better. Intraligamentous ovarian tumors offer the operator so many dangers, by their proximity to the large vessels, the uterus, etc., that their removal must necessarily be postponed unconditionally until they project up out of the pelvis, beginning to make the abdominal walls tense, and hence are more easily accessible.

Tauffer emphasizes from the experiences here made, that neither too great youthfulness, nor too great age, nor malignity of the tumor, kidney, nor heart affections, tuberculosis, very extensive adhesions, acute peritonitis, nor suppuration of the tumor should prevent one from operating, if the patient's life is in danger, and her rescue seems possible by the operation.

In spite of his extensive number of cases, Tauffer has among his 172 ovariectomies (among which he ten times, on account of grave complications, also super-vaginal amputation of the uterus, was added and obliged to be added) he only lost eighteen 10.4 per cent. ; among these seven from sepsis (4 per cent.).

His indications for castration are (1) Pathological changes of position of the ovaries, if they produce grave symptoms and are not to be relieved otherwise ; (2) Complete absence or rudimentary development of the uterus with normal ovaries, where ovulation causes much pain ; (3) Such diseases of the uterus, which, influenced by ovulation, are found to be cured after cessation of the latter, as intramural and ulcerous myomata, continually relapsing fungous diseases of the endometrium, membranous dysmenorrhœa, and many retroflexions otherwise incurable ; (4) Chronic inflammation of the ovaries and their surroundings in cases where the congestion accompanying ovulation keeps up a condition of inflammation and continually renews it ; (5) Grave diseases of the nervous system, which appear to be connected with ovulation and menstruation.

The thirty castrations and salpingotomies made by Tauffer recovered without a fatal case.

The radical treatment of uterine tumors he indicates: (1) Hæmorrhage—dangerous to life—not to be removed otherwise ; (2) Symptoms of pressure threatening life, as when the diaphragm is strongly pressed upwards, displacement of the heart, pressure

upon the large vessels, danger of incarceration, unbearable pains, etc.; (3) When the tumor grows rapidly, and (4) When any danger complication is present, or the nutrition of the patient sinks.

Every one of these conditions indicates operative procedure as soon as possible.

Among fifty-one hysterotomies made by Tauffer there were twelve deaths, hence a mortality of 22.2 per cent. In the treatment of the stump Tauffer is an adherent of the extraperitoneal method.

In thirty-five other cases a trial incision only was made or after opening of the abdominal cavity such an extension of malignant tumors upon the peritoneum or the walls of the intestines, that extirpation was impossible; of these fourteen inoperable cases, twenty-one died after a longer or a shorter time, while fourteen were cured by an operation.

Finally Tauffer mentions seven laparotomies with the following indications: old, irreplaceable inversion of the uterus; ileus, dependent upon carcinoma of the intestines; two cases of extra-uterine pregnancy at the end of pregnancy; two cases of hydro-nephrosis; four of separation of adhesions, which held the uterus retroflexed.

PINZONI, SECALE CORNUTUM IN THE PUERPERENT. *Bull. delle Sc. med. Bologna, Serie Vol. VI. XX.*—This work, showing a great and extensive knowledge of literature, is based upon the observations made upon ninety-one lying-in women to who secale c. was systematically administered (usually 2g. of the powder daily) and also seventy-nine other lying-in women, who received no medicine, served as a comparison with the others. These conclusions are as follows:

(1.) Secale c. has no influence upon the temperature, at the most it is slightly elevated; (2.) The pulse is somewhat increased, yet it has no marked influence upon the restoration of the pulse (physiological) of the first few days of the child-bed; (3.) The physiological increase in the diuresis in the first days of the child-bed is still increased by secale c.; (4.) The involution of the uterus is either not influenced at all or at the most delayed. The lochial secretion is kept normal by secale c. and coagula are most easily expelled. The lochia are less often evil-

smelling. Secale c. diminishes the after-pains of primiparæ and decreases those already present ; (5.) The lacteal secretion is retarded by secale c. diminished, sometimes completely suppressed. Secale c. seems to be a prophylactic against puerperal fever, an indirect antiseptic ; (6.) If infection be already present secale c. seems to hasten the penetration of the virus into the circulation.

ON A MURMUR IN EXTRA-UTERINE PREGNANCY. BY DR. PRACHET.—An extra-uterine blowing murmur forms in the maternal bloodvessels at the spot where the placenta is inserted at the wall of the extra-uterine cyst, as long as the foetus is alive or for a short time after its death. It is isochronous with the arterial pulse-beats of the mother, and stronger than the uterine sounds. It may give a hint for the operation where to find the placenta.—*Centralbl. f. Gynæc.*, 22, '89.

GENITAL TUBERCULOSIS IN WOMEN.—Thiereslin describes tuberculosis lesions occupying the vagina, uterus, Fallopian tubes, pelvic peritoneum. He found pulmonary lesions, but the whole course of the disease showed the genital organs to be the starting point in consequence of a miscarriage. The utero-placenta region being the entrance point of infection, and every other source of infection could be excluded.—*Bullet. Méd.*, 22, '89.

VAGINAL URETHROCELE.—Under the name of *urethrocele* is designated the dilatation of the inferior wall of the canal of the urethra in the female and its hernia into the vagina. The true urethrocele is that in which the tunics of the wall are simply altered and where it makes a real pouch at the expense of the peri-urethral tissues. There should be thus distinguished a simple urethrocele, and a complicated urethrocele, in which latter this lesion is accompanied by other like affections of the genito-urinary organs ; hernia of the vaginal membrane, cystocele, prolapsus uteri, etc.

As principal etiological factors we should note age, forty to fifty years, and accouchement, especially if this has been difficult. After some troubles of micturition more or less prolonged, the affection is found constituted by the functional symptoms. The

first are characterized by the state of the urine, which rarely retains its ordinary aspect. It is not clear, is thick, has a deposit of mucus, is irritating, and causes erythema of the vulva and thighs. Little by little the patient is rendered conscious of the existence of a tumor, which may remain confined to the vaginal entrance or may protrude from the vulvular orifice, undergoing alterations of repletion and depletion. Vaginal touch then finds, immediately outside the meatus or rarely a little deeper, but always on the path of the anterior half of the urethra, the presence of a tumor of which the volume varies from the size of a hazelnut to half a hen's egg. This tumor is rounded, fluctuating, covered by healthy mucous membrane, sometimes painful to touch. In certain cases it is emptied through the meatus, under the influence of simple pressure. The tumor is besides easily seen when the vaginal walls are separated by means of a speculum. The functional symptoms consist especially in troubles of micturition : the patient frequently feels the need of urinating, which obliges her to rise many times each night ; she urinates with difficulty, an interrupted stream, and she feels that she has not completely emptied the bladder. At the same time she feels in the urethra a sensation of burning, which can become pain and determine crises affecting the form of veritable neuroses.

This frequency of urination may alternate with retention and incontinence of urine. The last is especially frequent, and the patient cannot walk or dance, without feeling wet from the urine which escapes involuntarily. Coitus is obstructed by the presence of the urethrocele and by the escape of the urine on attempts at intercourse. The nervous troubles which often accompany this affection may assume great intensity, and M. Duplay has seen a patient in whom occurred, as a consequence of the trouble of micturition, convulsive crises of great violence. Habitually slow, the course of the urethrocele is rather progressive than regressive, although a spontaneous cure has been witnessed ; more than this, it may be accompanied by complications which are the development of calculus in the sac, of cystitis, of urethro-vaginal fistula, of hernia of the vaginal mucous membrane, of uterine prolapsus and even rectocele.

In spite of its complications, urethrocele is not a grave affection,

it is an infirmity ; but it is necessary to recognize that this infirmity may attain a high degree. The irritable urethrocele, if one can thus call the neurotic form, is happily the most rare.

The treatment, which may be simply medical, consists first of all in local applications ; these are regular lavages of the urethra and the sac of the urethrocele with tepid water ; hot vaginal injections ; cauterizations and erosions of the membrane with nitrate of silver. The patient should besides take in urinating certain precautions, which consist in assuming for this function the genu-pectoral position, and in applying a finger towards the urethrocele, all to the end of impeding the dilatation of the sac during micturition. In grave cases, a surgical intervention is necessary, and the operation consists then in simple incision, or in resection, or in the excision of the tumor when it is very large.—*Gazette de Gynécologie*.

GYNÆCOSMOS.

—One of the recent graduates from the Women's Medical College of Pennsylvania is a native Indian, Dr. Susan La Flesche. The impulse to a professional career was the worthy desire to see her people independent of unskilled "medicine man."

—The relative power of the imagination in the two sexes was recently tested by Dr. Durand. To 100 hospital patients he gave a dose of sweetened water, and shortly afterward returned, apparently much agitated, declaring that by mistake he had administered a powerful emetic. Four-fifths of the patients were speedily affected by the supposed emetic, the majority of them being men, while every one of those not affected were women.—*Medical Era*. Tally one for the girls.

—The general assembly of "The Union of the Women of France" was held on June 11th. The Union has about 21,000 members divided into 179 committees. The society possesses a number of hospitals containing about 6000 beds, a number which can be considerably augmented on a few days notice.

BOOK REVIEWS.

THE EAR AND ITS DISEASES. By SAMUEL SEXTON, M.D., edited by CHRISTOPHER J. COLLES, M.D. William Wood & Co., N. Y.

This book is a most worthy candidate for the favor of the aural specialist. Its text includes many things of value omitted from works of previous date. What we design to specially notice, however, is its peculiar adaptation to wants of the general practitioner. This arises from the thoroughness with which the author describes, in Chapter V., the effects on the ear of heredity, of cachexia, of defective hygiene, and of the acute infectious diseases (scarlet fever, measles, variola, diphtheria, cerebro-spinal meningitis, etc.). In children, if the family physician would only insist on prompt treatment for the results of acute infectious diseases, many sad cases of ear diseases might be avoided, and to this end we most earnestly recommend this portion of the work as most likely to impress the physician with the responsibility which is so often unrecognized in the sequelæ of the exanthemata.

OPHTHALMOLOGY AND OPHTHALMOSCOPY. By DR. HERMANN SCHMIDT-RIMPLER; edited by D. B. ST. JOHN ROOSA, M.D., LL.D. William Wood & Co., New York, 1889.

This translation from the third edition of Dr. Schmidt-Rimpler's work is abreast of all improvements in ophthalmology. The most recent advances, such as the use of cocaine, and more exact measurement of the light sense, have been introduced and carefully considered. We are now in an age of medicine when it is an imperative necessity that the general practitioner should understand enough of the fundamental principles of ophthalmology to enable him to formulate hygienic rules for his patients when he sees that the organ of vision is in danger. Not that we believe in his assuming the function of the specialist, but that he should know when his province ends and that of the oculist begins. And more than this, the general practitioner in his duties as family physician has an influence which the specialist can never assume. It is the duty of every physician to watch carefully the hygienic conditions surrounding the children's eyes among the families of his patients, as he may thereby save many a child from partial or total loss of vision. This work of Schmidt-Rimpler's is especially designed for practitioners and students of medicine, and meets with our favorable judgment as one of the best of books from which to acquire that general knowledge of ophthalmology of which we have spoken. We can only find one fault: the author has given the work the stamp of a German individuality, for the work of many really distinguished French authorities is passed over in silence.

